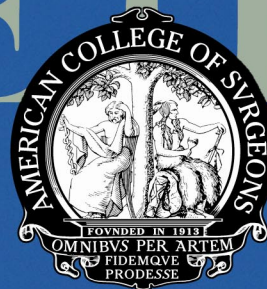


BULLETIN

AMERICAN COLLEGE OF SURGEONS



September 2001
Volume 86, Number 9

*American College
of Surgeons*



Strategic plan
for 2001
and beyond



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About the cover...

The Board of Regents this past June approved a strategic plan and a new organization structure for the College. The "Strategic plan for 2001 and beyond" (p. 9) summarizes the College's efforts to develop a mechanism to better respond to the needs of surgeons and their patients now and in the future.

As ACS Executive Director Dr. Thomas R. Russell notes in his column (p. 4), "The real work now begins as we start to implement this blueprint and to make certain that we do not vary from the values that have been espoused, particularly the many references to improving care for the surgical patient."

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2002 Young Surgical Investigators' Conference

The Surgical Research and Education Committee of the American College of Surgeons has organized the Sixth Biennial Young Surgical Investigators' Conference to assist surgeon-scientists who are entering the process of obtaining extramural, peer-reviewed grant support for their work. The goal of these conferences, held with staff members of the National Institutes of Health (NIH) in attendance, is to introduce young surgeons to the process, the content, the style, and the people involved in successful grant-writing and interactions with the NIH.

The program will include intensive exposure to:

- NIH programs and policies
- Information from NIH Institutes
- What programs are best and available for your research project and how to apply
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Grant-writing strategies
- Mock study sections reviewing model grants

The program and registration form are available online at <http://www.facs.org/dept/serd/srec/youngsurg.html>. For further information, contact Ms. Jan Fair, Administrative Associate, Education and Surgical Services Dept., American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; phone 312/202-5354; fax 312/202-5013; e-mail jfair@facs.org

March 8-10, 2002

*Lansdowne Resort
Conference Center
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*Sponsored by the
Surgical Research and Education Committee of the
American College of Surgeons*

From my perspective

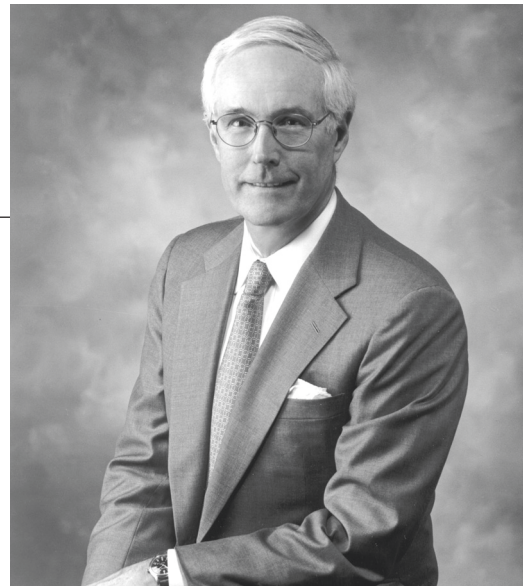
Strategic planning is not an easy exercise. The special report “Strategic plan for 2001 and beyond,” on page 9 of this issue of the *Bulletin*, outlines the College’s efforts over the last year-and-a-half to engage in an effective, future-oriented planning process. Clearly, a plan of this sort is never complete and must be looked upon as a vibrant and dynamic document—a blueprint for action today with room for additional growth and change tomorrow.

A great deal of thought and reflection on the past, present, and particularly the future went into the development of this document. College staff have met on multiple occasions to assess the various programs that are currently in place and their relevance today and in the coming years. In addition, the College sent surveys to randomly selected members of the College and to all of the chapters. Also, the reports from the Governors, which are received annually, were reviewed once again to obtain ideas about future initiatives; the specialty societies were polled to determine which areas they believe are of greatest concern and worthy of new and innovative approaches and strategies; and our Regents and Officers provided their ideas and input. Thus, the resulting document truly represents a Collegewide effort in planning for the future.

Complicating factors

While strategic planning is inherently grueling for any organization, charting the course for the future of any health care organization is further complicated by the very fluid environment in which medicine is practiced today. There obviously is great tension in the system, and virtually all stakeholders are sounding the cry for some sort of systemic reform.

Additionally, we needed to factor in the changing values and perceptions not only of our current members but of our potential members who are now in college, medical school, or residency training. We are faced with a younger generation who are not inclined to join organizations unless they see very real value directed toward them. At the



“As we look back five to 10 years from now, I anticipate we will hear a universal sigh of relief that in-depth planning was done at this time.”

same time, this new generation holds somewhat different values than their predecessors did, and they expect more balance, variety, and time for other interests in both their professional and personal lives. We are also witnessing shifting demographics in the medical workforce with a welcoming of more women and minorities into the surgical profession. As the College evolves, we must be aware of these dynamics, and I believe we must become more inclusive and relevant to the needs of a younger, more diverse pool of potential members.

Status of the plan

This planning document and a new organizational structure for the College were approved by the Board of Regents this past June. Under this proposal, the College will transform itself from an organization with some 14 departments to one

centered on four divisions—education, research, advocacy and health policy, and member services. Appropriate centrally oriented support services will exist for all of these divisions.

In addition, strategic initiatives have been developed for each of the divisions, and each division head will be held accountable for following through on his or her respective responsibilities. Changes and future iterations will be a natural part of this evolving process.

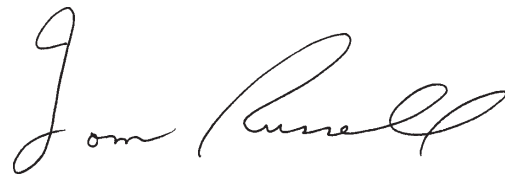
Just the beginning

The real work now begins as we start to implement this blueprint and to make certain that we do not vary from the values that have been espoused, particularly the many references to improving care for the surgical patient. There will naturally be constructive debate in the future as we further define who we are and what we expect to accomplish.

Throughout this planning document you will see references not only to surgeons, but to surgical patients as well. As a result, I believe an important question for us to consider today and into tomorrow is: Can we continue to survive in the future as an organization composed of just surgeons? Or could we better fulfill our vision as an organization that would include other health care professionals under our venerable institutional umbrella? In the past, we have attempted to form liaisons and relationships with multiple organizations, including those representing other branches of medicine, nursing, and so on, as well as with governmental agencies. In the future, perhaps we should consider expanding the categories of membership in the College to include other key stakeholders in the care of the surgical patient, such as anesthesiology, nursing, consumer groups, allied health professionals, and others yet to be determined.

As we look back five to 10 years from now, I anticipate we will hear a universal sigh of relief that in-depth planning was done at this time. This strategic plan represents our best current thinking, but it is more than likely that as we move ahead in the coming years, there will be

other ideas that should be pursued. As always, I invite your comments with respect to issues in the strategic plan itself, as well as other areas you believe should be addressed in the future.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

This column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is “hot news” to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College’s weekly electronic newsletter, ACS NewsScope.

❖ On August 13 and 14, the College and Andrew Warshaw, MD, FACS, hosted six congressional aides at Massachusetts General Hospital as part of the College’s **Day in Surgery Program**, which allows congressional aides to team up with surgical residents to learn firsthand about patient care, surgical training, the operating room environment, and the daily routine of surgeons in the hospital setting. And on July 20, Fellows from the College’s **Committee on Young Surgeons** met in Washington, DC, with their Members of Congress and their respective aides to discuss support for a Patients’ Bill of Rights and opposition to federal limits on resident work hours.

❖ In recent weeks, Thomas R. Russell, MD, FACS, Executive Director, visited the **North Carolina** and **Hawaii Chapters**. He also participated in the Presidents’ Forum sponsored by the **American Medical Association**, attended a strategic planning session of the **American Society of General Surgeons**, and visited the **Residency Review Committee for Otolaryngology**.

❖ Fellows and Associate Fellows may participate in the *Journal of the American College of Surgeons* **Online CME-1 Program** and earn up to two CME Category 1 credits each month. Visit <http://jacscme.facs.org/> to read each month’s designated articles and participate in an exercise in which you evaluate relevant clinical material from the article and apply it to clinical practice. This program is a membership benefit, so you will need to use your Fellowship identification number to access it.

❖ 1,455 hospitals now have approved cancer programs that meet standards of the **Commission on Cancer**. During the last survey year, the number of programs with full approval increased by 10 percent. A re-vamping of the cancer program standards and survey process is under way to incorporate patient data from the National Cancer Data Base (NCDB) and to include quality of care measures important to assessing cancer care patterns and outcomes. Changes to the NCDB patient data set include collection of more contemporary treatment ascertainment and data to allow risk as well as disease-specific stage-adjustment of outcomes.

❖ LaSalle D. Leffall, Jr., MD, FACS, a Past-President of the College, will be the principal speaker at the **13th Annual Fellows Leadership Society (FLS) Luncheon**, which will be held Monday, October 8, during the Clinical Congress in New Orleans, LA. The luncheon recognizes Fellows and friends who are donors to the College at the level required for membership in the FLS. To join the FLS, contact Robert E. Berry, MD, FACS, through the ACS Development Office (312/202-5376).

Dateline|Washington

prepared by the Division of Advocacy and Health Policy

House passes Patients' Bill of Rights

On August 2, the House of Representatives passed an amended version of H.R. 2563, the Bipartisan Patient Protection Act of 2001. The original bill was introduced by Reps. Greg Ganske, MD, FACS (R-IA), John Dingell (D-MI), and Charlie Norwood (R-GA), and supported by the College. However, earlier this year President Bush indicated his opposition to the legislation because of provisions pertaining to health plan liability.

During the debate, three amendments to the bill were offered: (1) an expansion of medical savings accounts; (2) the establishment of medical liability reforms for physicians, hospitals, and other health care providers; and (3) a compromise proposal reached between Representative Norwood and the President that placed restrictions on health plan liability. The expansion of medical savings accounts and the Norwood/Bush compromise both passed on essentially party-line votes, with Republicans supporting both amendments. The medical liability reform amendment, which was strongly supported by the College, lost on a vote of 208-221. The final amended bill passed the House by a vote of 226-203.

The House bill must be reconciled with different legislation that the Senate passed in early July. Most important, the House-Senate conference committee that should begin meeting in the fall will need to find common ground on the health plan liability issue. For example, the House bill limits noneconomic damages to \$1.5 million, while the Senate bill contains no cap on noneconomic damages.

ACS comments on Medicare five-year review

On August 7, the College submitted comments to the Center for Medicare and Medicaid Services (or CMS, formerly the Health Care Financing Administration) on the proposed notice giving the results of the five-year review of the physician work values listed in the Medicare fee schedule. The five-year review began in March 2000 when the ACS identified 314 CPT codes in 31 general surgery procedure families as being misvalued. The codes were referred by CMS to the AMA/Specialty Society Relative Value Scale Update Committee (RUC) for revaluing. Ultimately, CMS accepted the RUC's work value recommendations for 278 codes in 25 different procedure families. However, the agency rejected the RUC's recommendations for 36 codes, because the suggested values would have produced rank order anomalies within the six service families involved. Instead, CMS followed the advice of the College and increased the work for all 36 codes. The changes made during the five-year review of physician work translate into a 4 percent average increase in payments to general surgeons in 2002, assuming all else remains constant.

The most controversial issue addressed in the proposed rule involved inclusion of critical care in the valuation of certain procedure codes (in which critical care is a routine part of the postoperative care). CMS questioned whether Medicare might be making duplicate payments for critical care—once to the surgeon and once to another physician assigned to the intensive care unit. The agency made clear that it will not change Medicare's critical care payment policy in 2002, but asked

CMS proposes changes in payment policies

for comments on various changes that could be made for 2003. The College objected strongly to all the proposed changes because they would violate the ethical standards of the College on postoperative care, as well as Medicare's own global surgery policy. Furthermore, the College was joined by 30 other specialty societies, including most major groups with members who provide critical care, in signing a letter urging that no policy or payment changes be made.

CMS published its plans for continuing to refine the resource-based practice expense relative value units in a proposed rule on the 2002 Medicare fee schedule that was issued on August 2. The draft regulation also proposed a number of payment policy changes for 2002, none of which is expected to have a significant impact on surgical services.

The proposed rule did, however, seek information pertaining to payments for co-surgeons (CPT modifier -62); that information could be used to decide whether a policy change for 2003 is necessary. CMS appears to be concerned about two things: (1) the possibility that a surgeon can seek much higher reimbursement as a co-surgeon than as an assistant at surgery; and (2) whether it is possible to set a more precise payment amount for co-surgery. (Currently, both of the co-surgeons are paid 62.5 percent of the Medicare fee schedule amount, as opposed to an assistant at surgery who is paid 16 percent of the primary surgeon's global service amount.)

This proposed rule also projected the changes in payments that would result from the five-year review of work, the changes made to practice expense relative value units, and other miscellaneous changes. The big "winner" is general surgery with a 4 percent increase. Other gains were made by vascular surgery (with a 2 percent increase) and thoracic surgery, urology, and obstetrics/gynecology (with 1 percent increases). Ophthalmology took a 1 percent loss. These estimates must be interpreted with some caution, however, since the annual update that will be applied to the fee schedule conversion factor in 2002 is not yet known (and may, in fact, be a negative number).

PROs ordered to disclose information

In a recent decision, a judge in Washington State ordered the CMS to force peer review organizations (PROs) to give Medicare beneficiaries access to reports on investigations into complaints about substandard care. PROs were created initially to ensure that services provided to Medicare beneficiaries were reasonable and necessary, in addition to investigating beneficiary complaints and violations of the Emergency Medical Treatment and Active Labor Act. Until this recent decision, CMS has barred PROs from disclosing information on investigations, fearing physicians would not cooperate with reviews or speak honestly about events if the results could be used against them in malpractice lawsuits. The agency is currently reviewing the decision to determine whether to appeal or seek a stay of the order.

*American College
of Surgeons*



Strategic plan
for 2001
and beyond



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Dear Colleague,

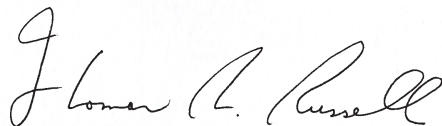
From time to time over the years, the Board of Regents has felt the need to hold special planning meetings to allow for in-depth discussion of major issues confronting the surgical profession and to consider possible new directions for future College activities. Thus, as part of their June 8-10, 2001, meeting, the Regents held a special strategic planning retreat at ACS headquarters. Over the course of the two-and-a-half-day meeting, the past, present, and future of the surgical profession and of the College itself were reviewed and discussed in-depth.

The purpose of the retreat, of course, was to determine the College's priorities in order to ensure that our programs benefit our patients and meet our members' needs in today's environment. An outcome of the retreat was a decision to focus College resources and activities on four major areas of concentration: education, research and optimal patient care, advocacy and health policy, and member services. With the Regents' approval, we have begun the process of restructuring so that we will be organized in the most effective fashion to meet our members' and their patients' needs.

During the strategic planning retreat, the Regents also approved the establishment of an Office of Evidence-Based Surgery at the College to process and analyze data leading to best practices and potentially to clinical trials in areas other than oncology. They supported increased efforts to further the activities of the National Trauma Data Bank, and they agreed to an in-depth investigation of the possibility of forming a College 501(c)6 organization. They are giving serious consideration to a program that would strengthen brand identity for "FACS" through a marketing/advertising program, and they will entertain a formal proposal for such a program at their meeting in October.

Much of what the College seeks to achieve through this reorganization and reevaluation process is identification of our common ground and unification of all specialties under one surgical umbrella. Regardless of specialty, we all have so much in common in today's complex and challenging environment. The College needs to take advantage of the opportunities that exist to bring all of surgery together and to focus on our similarities rather than on our differences.

This strategic plan for the College is a blueprint for change that recognizes that the planning process is a continuous and dynamic process. Every effort has been made to structure the plan such that it can adapt to a constantly changing environment. The Board of Regents is committed to continuously reviewing the components of this plan to ensure that the College will continue to meet the needs of surgical patients and its members.



Thomas R. Russell, MD, FACS
Executive Director

~ Mission

The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

~ Vision

As an association of surgeons, the American College of Surgeons is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients. The College provides a cohesive voice addressing societal issues related to surgery.

The American College of Surgeons supports programs and policies that ensure patients access to optimal, effective care provided by appropriately prepared and well-qualified surgical specialists of their choosing. Such care should be delivered in a system that provides maximum safeguards for patient safety. Since 1913, the College has initiated programs that have promoted the well-being and protection of patients both within and outside the hospital environment. The American College of Surgeons will work with interested and qualified parties to optimize patient welfare and safety.

~ Areas of primary focus

Education

- Facilitate and provide educational opportunities to further quality care.

Research and Optimal Patient Care

- Advance the practice of surgery through research and scholarly activity to advance knowledge culminating in optimal patient care.

Advocacy and Health Policy

- Effectively represent the interests of patients and surgeons.

Member Services

- Assist members in the development of an optimal and ethical practice environment for the benefit of the surgical patient.

~ Goals and objectives

To provide assurance to its Fellows and their patients that it will fulfill its mission and implement its vision, the American College of Surgeons has established the following goals. Through its programs and services, the College will meet specific operational and program objectives in each of its primary focus areas.

In Education, the College will provide programs that meet the educational needs of surgeons and the public and assist surgeons in their

responsibility to maintain competence, lifelong learning, and professionalism.

Objective: Develop innovative delivery methods for educational activities.

Objective: Assist members in meeting educational quality measures, such as CME.

Objective: Develop and enhance patient educational materials relative to surgical care.

Objective: Develop educational products designed to meet the needs of surgeons.

Objective: Facilitate access to volunteer opportunities for surgeons.

Objective: Assist members in documenting relevant activities for various reporting requirements.

In Research and Optimal Patient Care, the College will advance the practice of surgery through research and scholarly activities to expand medical knowledge.

Objective: Provide opportunities for scholarships and fellowships.

Objective: Educate surgeons about funding and research-related activities.

Objective: Facilitate involvement in research activities, such as clinical trials and outcomes efforts.

Objective: Develop strategies to improve philanthropic activities.

In Advocacy and Health Policy, the College will be the recognized authority on issues related to surgery and care of the surgical patient and effectively represent the interests of patients and surgeons.

Objective: Develop strategies to provide high-quality and safe care for surgical patients.

Objective: Develop effective communications strategies to interface with legislative and regulatory bodies.

Objective: Enhance public relations activities to advocate effectively for patients and surgeons.

Objective: Interact effectively with the health insurance industry.

Objective: Interact with other members of the health care community.

Objective: Facilitate debate regarding public policy on issues affecting surgical care at both the local and national levels.

Objective: Enhance the ability to identify, prioritize, and promote public policy issues relative to surgical care.

Objective: Enhance communications efforts regarding the College's activities in this area.

In Member Services, the College will remain a major professional association for all surgical specialists and will meet the needs of surgeons with programs and services that help them adapt to a changing health care system.

Objective: Improve communications between members and leaders of the ACS.

Objective: Enhance the meaning and value of "FACS" for surgeons and the public.

Objective: Encourage interaction with other surgical specialty groups to address shared interests.

Objective: Explore opportunities to expand membership, both domestic and international.

Objective: Educate and train surgeons in the evaluation and use of new technology.

Objective: Establish a "customer service" approach to the provision of membership services.

Objective: Provide services that are directed toward meeting the socioeconomic and business needs of members.

~ Planning

The Board of Regents realizes that planning is a continuous and dynamic process. Therefore, this plan must be structured such that it can adapt to a changing environment. The Board, its committees, and the staff must continuously review the components of this plan to ensure that the College continues to meet the needs of surgical patients and its members.

~ Structure and support

If the programs and services of the College are to be implemented in an effective and efficient manner, an organizational structure that reflects the priorities of the College must be in place. That is also the case with regard to the staff structure, which in many instances must be a reflection of the leadership matrix that is put in place to implement the policies of the Board of Regents. An organization that works together in a cohesive and collegial fashion to champion the needs of surgical patients and of its members will have no limits to its success. To assist in achieving such success, administrative support will be provided in the areas of communications, executive services (including development), finance and facilities, human resources, and information services. A function of the Board of Regents and the Executive Director, therefore, is to ensure the creation and support of such an organizational and staff structure.

~ Programs and strategies

The future development of key programs, strategies, and services will make this a living and vibrant document. These are the programs that will ensure that the College will implement and achieve its goals and objectives. These programs must have the following components when presented to the Board of Regents. They will:

- Relate to the mission, vision, and goals of the College.
- Have a business plan to ensure that programs are practical and financially reasonable.
- Identify the expected outcome and the timetable for achieving outcome(s).
- Have an evaluation template to determine levels of success.
- Have review timelines to ensure regular and timely oversight.

It is the responsibility of the College's committees and the Executive Director to ensure that these programs, strategies, and services are prepared in this manner and that they are presented in an effective and timely fashion to the Board of Regents. □



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Scrutiny of
EMTALA
grows
as its scope
e x p a n d s

by
Christopher Gallagher,
*Senior Government Affairs Associate,
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On April 7, 1986, President Ronald Reagan signed into law the Consolidated Omnibus Budget Reconciliation Act of 1985, which incorporated legislation known as the Emergency Medical Treatment and Active Labor Act (EMTALA) to address the problem of “patient dumping” by hospital emergency departments. While originally designed to serve as a safety net for emergency patients, the statute has grown tremendously in both scope and complexity over the last 15 years. As a result of increased “regulatory guidance” and judicial action, EMTALA mandates now cover virtually every area of a hospital and its satellites. Hospitals, which are required to maintain back-up call services around-the-clock, are continually pressing specialists into service. Given an environment in which regulatory burdens and federal oversight are rising, payments are falling, and overall responsibilities are expanding, many surgeons are finding it extremely difficult to maintain their practices and adhere to the strict, unfunded mandates of EMTALA.

This article focuses on the current requirements for hospitals and physicians under EMTALA, the latest government reports examining the impact of the statute, and possible refinements to the law.

Current status

In the mid-1980s, legislators heard disturbing anecdotes of a growing public health problem associated with hospitals that refused to provide care in the emergency room to uninsured and underinsured patients. In response, Congress passed EMTALA. Although originally defined as covering individuals that present to the emergency department, the regulations that implemented that law now are interpreted as applying to the entire hospital grounds, including physicians’ offices within the hospital.

As a result, many physicians, and even hospitals, are confused about their responsibilities under EMTALA. Currently, the law requires Medicare-participating hospitals to provide a medical screening exam to any individual who comes to the emergency department seeking examination or treatment for a medical condition. If hospital staff determines that an individual is experiencing a medical emergency, the patient must then

be stabilized or appropriately transferred. The hospital is obligated to provide these services regardless of the patient’s ability to pay and without waiting to inquire about method of payment or insurance status. In addition, the statute requires hospitals to maintain a back-up call system for any service for which the hospital promotes itself to the community. Failure of hospitals or physicians to comply with any EMTALA-mandated responsibilities can result in fines of from \$25,000 to \$50,000 for each infraction.

Responsibilities under EMTALA for physicians serving on these “back-up call systems” have become a major issue for surgeons and other specialists. Over the last few years, many specialists have become more reluctant to take call at hospitals. These staffing shortages most often occur because the community in which the hospital is located does not provide a sufficient base of patients to support enough specialists in a particular field or because certain services are not offered at the hospital. In addition, significant reductions in payments for surgical services under Medicare’s resource-based physician payment system and the managed care industry’s reluctance to pay for many EMTALA-mandated services have further exacerbated this problem.

OIG examines EMTALA

On January 22, the Department of Health and Human Services’ Office of the Inspector General (OIG) released two reports regarding EMTALA. The first, *Survey of Hospital Emergency Departments* (see box, p. 18), describes the results of a mail and telephone survey of emergency department managers, physicians, nurses, and registration staff, as well as on-call physicians, regarding each group’s familiarity with EMTALA mandates. One concern respondents raised pertained to the cost of uncompensated care and difficulties in staffing on-call panels. Respondents also identified neurosurgery, cardiovascular surgery, pediatrics and its subspecialties, orthopaedic surgery, and ob-gyn/neonatal services as the top five specialties of concern regarding on-call coverage.

The second report, *The Enforcement Process* (see box, p. 18), examines the mechanisms by which the federal government enforces EMTALA and suggests areas in which the Centers for Medicare

Provider uncertainties about EMTALA requirements

Issue	Requirement	Provider uncertainty	CMS comment ¹
Medical screening exam	Individuals must be given a medical screening exam that determines presence or absence of an emergency medical condition.	How the exam differs from triage or a general exam.	Interpretive guidelines say triage determines order in which patients will be seen, not presence or absence of an emergency medical condition. CMS is not currently developing additional guidance.
Stabilizing treatment	Patient must be stabilized. CMS uses terms “stable for transfer” (physician believes patient’s condition will not materially worsen during transfer to another facility) and “stable for discharge” (patient can reasonably be cared for as outpatient or later as inpatient).	Whether the determination that a patient is stable for transfer or discharge ends the hospital’s EMTALA obligation or whether the hospital must also ensure follow-up care is provided.	The requirement is fulfilled when a physician determines the patient is stable for transfer or stable for discharge. The regulations on transfer requirements refer to patients who are unstable; therefore they do not apply when a patient is stable for transfer or stable for discharge. ²
Follow-up care	Stabilized patients must be given a plan for appropriate follow-up care.	Whether a hospital must ensure that follow-up care is obtained.	Hospitals are not required to ensure that follow-up care is obtained. CMS is not currently developing additional guidance.
250-yard rule	Screening and stabilization are required for all patients seeking emergency services within 250 yards of the hospital’s main buildings.	Who designates “main” buildings and how. Also, whether the rule applies to entities not related to the hospital, such as a restaurant or an apartment complex.	CMS officials are developing further guidance on how to apply the 250-yard measure and what properties are covered by EMTALA.
Hospital campus	Screening and stabilization are required at both on-campus and off-campus hospital departments. ³	Whether this applies to all individuals seeking care in departments that normally require an appointment.	It applies if the person says there is an emergency or a reasonable person would say there may be one. Further guidance is being developed.
On-call coverage	Hospital must keep a list of specialty physicians on call to stabilize emergency patients.	The extent to which physicians must be on call for each specialty a hospital has on staff. Some hospitals and physicians believe CMS requires full-time coverage of a specialty if the hospital staff includes three or more physicians in the specialty.	There is no rule linking extent of coverage with the number of specialists on staff. Physicians are not required to be on call at all times. Further guidance is being developed.
Ambulance	A hospital must screen and stabilize patients transported in ambulances the hospital owns or operates. ⁴	What to do when local emergency medical system policies mandate taking patients to the nearest hospital.	Compliance with local emergency medical system policies is acceptable, according to interpretive guidelines. Further guidance is being developed.

1. This column presents information CMS staff provided to us about each issue.
2. Transfer requirements include documenting the risks and benefits of transfers and forwarding the patient’s medical records to the receiving facility.
3. Off-campus departments include clinics, primary care centers, diagnostic facilities, and urgent care facilities for which the hospital has obtained designation as a hospital outpatient department.
4. The Ninth U.S. Circuit Court of Appeals also applied EMTALA to nonhospital-owned ambulances. The court said that hospitals could not turn away ambulances after radio contact is made unless they do not have the staff, facilities, or equipment to treat the patient. *Arrington v. Wong*, 237 F3rd 1066 (9th Cir, January 22, 2001).

Resources for surgeons to learn more about EMTALA

OIG report

EMTALA: The Enforcement Process

<http://www.dhhs.gov/progorg/oei/reports/a510.pdf>

OIG report

EMTALA: Survey of Hospital Emergency Departments

<http://www.dhhs.gov/progorg/oei/reports/a509.pdf>

GAO report

Emergency Care: EMTALA Implementation and Enforcement Issues

<http://www.gao.gov/cgi-bin/getrpt?gao-01-747>

AMA EMTALA Quick Reference Guide for On-Call Physicians

<http://a844.g.akamai.net/f/844/3591/3h/www.ama-assn.org/ama/upload/mm/21/emtala.pdf>

American College of Emergency Physicians' (ACEP) publication

Providing Emergency Care Under Federal Law: EMTALA

Copies are available for a fee from ACEP through calling 800/798-1822, touch 6, or 972/550-0911.

and Medicaid Services (CMS) could improve the process, including increased oversight of regional offices, improved data collection and access, and establishment of an EMTALA technical advisory group.

The release of both OIG reports, particularly the survey of hospital emergency departments, provided further evidence that the continual expansion of EMTALA mandates is seriously straining the patient care safety net. In addition to significant compliance costs for hospitals and physicians, patients are more frequently encountering overcrowded emergency rooms and reduced access to critical specialty emergency care.

Congress reacts to physicians' concerns

Congress has begun to recognize the concerns of the physician community and has expressed serious questions about the direction and impact of CMS's interpretation of the EMTALA mandates. Some of those concerns were acknowledged under provisions in the Medicare and Medicaid Benefit Improvement and Protection Act of 2000. One such provision directed the General Accounting Office (GAO), the investigative arm of Congress, to conduct an assessment of EMTALA and report its findings to Congress by May 2001.

GAO released its findings in June. Unfortunately, the agency's report, *Emergency Care: EMTALA Implementation and Enforcement Issues* (see box, left), failed to offer any concrete data regarding the effects of the statute on hospitals, physicians, or patients. Instead, the agency report essentially summarized concerns that have been publicly articulated by the provider and physician communities and highlighted the pillars of the enforcement process.

In summarizing concerns about the statute, GAO observed that hospital and physician groups indicate that implementation of EMTALA adversely affects the efficiency and type of services provided in hospital emergency departments, results in additional costs to hospitals and physicians, and leads to delays in delivery of care and overcrowded emergency rooms. In addition, some hospital and physician groups claim that fewer physicians are joining hospital staffs and participating in emergency department on-call panels because of the uncompensated care burden associated with EMTALA.

While acknowledging these concerns, GAO believes that other factors also contribute to these problems. Regarding overcrowding in emergency rooms, the agency said that the growth of the uninsured population and the difficulty some managed care patients may have in obtaining timely appointments with their personal physicians may also explain the increase in emergency department visits. In discussing the on-call issue, GAO stated that other factors, such as the ability to perform procedures in nonhospital settings, have reduced incentives for certain specialists to serve on hospital staffs.

One important point that GAO reaffirms from

the previous OIG reports is that CMS should re-establish a “stakeholder advisory group that could help CMS work with hospitals and physicians to achieve the goals of EMTALA and avoid creating unnecessary burdens for providers.” The need for such a group is clear, based on the number of concerns raised by hospitals and physicians over the uncertainty as to the extent of their responsibilities under EMTALA. The GAO report provides a brief table entitled, “Provider uncertainties about EMTALA responsibilities,” which appears on page 17.

College activity

The College has been closely monitoring this issue since rumors surfaced that CMS was poised to issue regulations to further expand EMTALA’s scope. In response, the College joined with other specialty societies on an EMTALA task force that is working with Congress and CMS regarding enforcement of the statute. This group sent a coalition letter, signed by 33 specialty societies, to CMS late last year to request a delay in issuing any further regulations expanding EMTALA.

Fortunately, on January 22, President Bush issued a regulatory review memorandum that delayed for 60 days the implementation of any final regulations published in the last days of the Clinton Administration that had not yet taken effect. In addition, any rules that were not published as of noon on January 20 were withdrawn for review and approval by the new Bush Administration. This action postponed approval and publication of a number of pending regulations, including any new regulations that would have expanded the scope of provider and physician responsibilities under EMTALA.

Another activity of the EMTALA task force has been the development of legislative language to reform certain aspects of the statute. At press time, members of the task force were finalizing the language and planning strategy for securing congressional support for the initiative. In an effort to lay the groundwork and build support for these legislative changes, College chapters have been raising this issue during their visits to Capitol Hill.

Earlier this year, the Board of Governors’ Committee on Socioeconomic Issues developed a white paper entitled *EMTALA, Straining America’s*

Health Care Safety Net. The document highlights the problems with current enforcement of the law and outlines possible solutions that Congress should undertake to ensure that America’s safety remains strong in the future. The white paper, which was unanimously approved by the College’s Health Policy Steering Committee, lists possible solutions for reforming EMTALA as listed below. (The entire paper can be viewed on the College’s Web site under “Legislative Action Center.”)

- The term “emergency condition” should be better defined and its limitations set. EMTALA should be limited to the hospital emergency department, as originally intended.

- The government should reimburse hospitals and physicians for services rendered under EMTALA mandates through Medicare, Medicaid, or some sort of uncompensated care pool. The present circumstance taxes doctors through an unfunded government mandate.

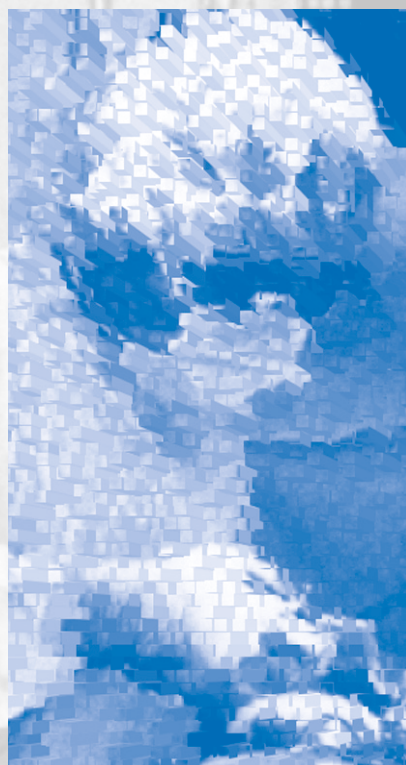
- Should the government fail to provide some form of coverage for services rendered under EMTALA, it should amend the internal revenue code to provide tax deductions to physicians who provide uncompensated care under the statute.

- Managed care plans should be mandated to pay for justifiable screening and treatment. The Medicare “prudent layperson” criteria for reimbursement of emergency room services should be extended to all private insurance plans. It is critical that there be such a standard for managed care plans that is defined, implemented, and based on symptoms, not on the final diagnosis. Furthermore, all health insurers should be held liable for failure to cover EMTALA-mandated services, and managed care plans’ preauthorization requirement should be eliminated for emergency care.

As Congress begins to learn more about the problems facing hospitals, physicians, and patients due to broadening EMTALA mandates, policymakers will, hopefully, respond with a legislative remedy. A major focus of the College’s lobbying effort will be to expedite this process. □

**Current
status
of the**

National Practitioner Data Bank



**by Josef E. Fischer, MD, FACS,
Boston, MA**

The National Practitioner Data Bank (NPDB) is an electronic repository that collects information on adverse licensure actions, certain actions restricting clinical privileges, and professional society membership actions taken against physicians, dentists, and other practitioners. In addition, the NPDB collects data on all payments made on behalf of physicians in connection with liability settlements and judgments.

The NPDB was established by Congress as part of the Health Care Quality Improvement Act of 1986 (HCQIA) (42 U.S.C. 11101, *et seq.*). The NPDB is administered by the Health Resources and Services Administration (HRSA), which is required to make the information gathered available to hospitals, state licensure boards, professional societies, and other health care entities. This information is presently considered confidential and is released only to the eligible entities or to physicians and other health care practitioners who seek their own data. The data are not intended to be released to attorneys unless it is proven that hospitals were negligent in not making an inquiry. Even so, "such information cannot be used against the practitioner."

At the time the NPDB was created, there was concern that insufficient data were exchanged between state licensing boards to prevent "bad doctors" from moving from state to state "without disclosure or discovery of [their] damaging or incompetent performance." Listing all payments and the other matters that were to be listed in the NPDB were seen as a way to prevent such physicians from moving without such information being available. Since then, there have been a number of improvements in the ability of states to obtain this information, including electronic linkages between state licensing boards, thus (among other things) making one of the principal reasons for the NPDB obsolete. However, other nonlicensing actions, such as clinical privilege actions and, of course, professional liability payments, are available only from the NPDB.

The NPDB does not require an annual federal appropriation to keep it in existence, as it is a self-contained bureaucracy supported by query fees. Hospitals are required to query the NPDB and its newly established companion, the Healthcare Integrity and Protection Data Bank (HIPDB), in a single query every two years when re-establish-

ing credentials for various practitioners, notably physicians. The HIPDB includes licensing and health care-related criminal convictions and civil judgments other than malpractice. It should be noted that there is a disparity in fees. While physicians are required to pay \$10 (\$20, in fact, because the HIPDB is also queried separately for an additional \$10), other entities only pay \$4.

From the beginning, the usefulness of the NPDB was impaired by the major reporting function being linked to payment, any payment, regardless of amount. Thus, payments that are the price of doing business (for example, out-of-court settlements of \$5,000 to \$10,000) are listed. Some states have recognized the lack of utility of such payments by establishing "floors" for the amount that must be reported. The NPDB by law does not have such a minimum payment threshold. Currently, the listing of practitioners is increasing by 10 percent annually, and 164,319 practitioners were listed at the end of 2000. Some of the leaders in American surgery have claimed that in time the NPDB will be like a phone book. Indeed, that is where we seem to be headed. Currently, 20 percent of medical practitioners are listed. This means that if malpractice payment is equated to practicing below the standard, either 20 percent of our practitioners are practicing below the standard, in which case American medicine has one heck of a problem, or that listing does not reflect the original intent.

Problems with the NPDB

The NPDB was seen as flawed from the beginning. Numerous individuals detailed specific problems with the NPDB as originally envisioned, including:

- *No threshold for payment.* Payments are listed regardless of the amount. Thus, a \$5,000 payment has the same value as a \$5 million payment. Some states—such as Georgia, Ohio, and California—have thresholds of \$10,000, \$25,000, and \$30,000, respectively, suggesting that at least in their eyes, payments below those amounts are the price of doing business and that it would largely be cheaper to pay rather than to defend the lawsuit.

- *Inadequate linkage of two or more payments for the same event.* By its own admission, the NPDB

cannot differentiate between two payments made for the same event or two separate episodes. Thus, although the number of practitioners with two listings is relatively small, the inaccuracy of the data makes it difficult to evaluate those fewer than 2 percent of physicians that have three or more listings. Again, the weakness of the data makes it difficult to judge whether these are separate events or if at least two of the listings are for the same events. According to staff of the NPDB, this problem is being resolved, but past data remain suspect.

- *Forever listed.* Once a physician or practitioner is listed in the NPDB, the file remains for the existence of the physician's career. There is no provision, for example, for a physician who has had a listing, say in 1990, having his or her name being put to a separate part of the memory in the year 2000 despite having practiced for 10 years without a subsequent payment. While some have made the argument that licensing actions are listed forever, I would argue that licensing actions are of much greater significance than payment.

- *Normalized risk.* The risk of a given practitioner's specialty is mentioned nowhere. Some specialties are inherently risky. The normal rate of claims, therefore, differs among the specialties. Some states that collect practitioner data, such as Massachusetts, introduce each section of a physician's profile by saying that "the norm in this particular specialty is X payments over 10 years." No such information is available from the NPDB. This is important if one really intends to equate listing for payment with practice below the standard.

- *Equating payment with malpractice.* The original intent of the NPDB was not to equate payment with below-standard practice; Section 427(d) of the HCQIA acknowledges that physician liability payments do not indicate that negligence has occurred:

Interpretation of Information—In interpreting information reported under this part of payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that malpractice has occurred.

Nonetheless, physician presence in the NPDB has evolved to the point where practitioners listed

are seen by some individuals as practicing below the standard.

- *Residents are listed in the NPDB.* At the end of 2000, a total of 1,356 physicians were listed in the NPDB for payment for events that took place during residency. The author receives communications from residents indicating that they are being listed for events that happened during their tour of duty as residents and for which they, therefore, theoretically have no final responsibility. There are certain circumstances in which residents are operating as independent practitioners: for example, moonlighting, and in those cases, they should take responsibility for their own actions. However, within the parameters of the Accreditation Council on Graduate Medical Education, residents are never ultimately responsible for patient care; the attending physician is culpable. Thus, listing is inappropriate, providing the resident did not egregiously act on his/her own. It is true that the NPDB has no alternative but to include residents, as the law says that anyone for whom payment is made should be listed, but there should be some way this flaw can be corrected.

- *Informing the listee.* Individuals who are listed in the NPDB are informed by mail. Because residents and young staff physicians may move several times after the event and the time from when the event occurred to payment is currently a median 3.8 years, it is likely that the final listing will take place when the resident has completed the residency and has moved at least once. Thus, an interesting scenario: The potential staff person is asked to list any professional liability payment or adverse action on his/her application. The candidate has no knowledge of the listing and, thus, responds that he or she is not aware of any payment. A separate query by the hospital or HMO or other health care entity reveals a listing. Now, in addition to being listed, the application is considered fraudulent, with devastating effects on his or her ability to practice, including exclusion from panels, exclusion from hospital privileges, and charges of fraud (including at the state licensing board). These charges, of course, are unintentional but, nonetheless, the hapless applicant must hire an attorney, generating great expense to someone who can ill afford it.

Attempts to address this situation have been met with a sympathetic ear from HRSA, and some dis-

cussion has occurred, but, as yet, no real progress has been made. Part of the reason may be the structure of the NPDB and its relationship with the executive committee, which is composed of representatives of physician and provider organization and of which I am a member. In fact, there is no official relationship between the executive committee and HRSA, which is the controlling government body. The only relationship the executive committee has is with the contractor that runs the NPDB. To be sure, there has been an attempt to make the executive committee more useful, for example, in electing a chair and a vice-chair who help set the agenda. However, in terms of actual ability to do anything, the executive committee seems to be a toothless tiger. Now, though, there is a new individual who is attempting to interact with members of the executive committee, for which I applaud the NPDB.

Unfortunately, the overall response from HRSA to changing the method of notification, attempting to locate people who actually have been listed, if they have been listed for the first time, and making it easier for individuals who have been listed in error to be unlisted, has been weak, as the General Accounting Office (GAO) report described below indicates.

- *Gouging of practitioners.* The last issue that sticks in the craw of physicians is the fact that we pay \$20 to inquire, whereas HMOs and hospitals and other organizations pay only \$8. Whereas physicians pay \$10 to inquire electronically over the NPDB, they simultaneously query the HIPDB, resulting in a total charge of \$20 per self-query. This issue was raised at a recent meeting of the executive committee, and we were informed that this problem is unlikely to change given the budgetary difficulties anticipated for the next fiscal year. To be fair, I should mention that the staff claims that most hospital and payor queries are answered automatically without human intervention, whereas self-queries are separately printed and mailed, and require human intervention, meaning greater processing costs.

The GAO report

The GAO report to the Chairman of the House Committee on Governmental Reform Subcommittee on the National Economic Growth, Natural

Resources and Regulatory Affairs, is titled, “Major Improvements Are Needed to Enhance the Data Bank’s Reliability.” The report is highly critical of almost every aspect of the operation of the NPDB. At a time when there have been calls from well-meaning but ill-advised consumer groups to make the data in the NPDB public, the idea of doing so is not only frightening, but misguided. The GAO report clearly indicates that in addition to problems in the running of the NPDB, there is a great deal of inaccuracy in the data contained therein. Specifically:

1. There are many major criticisms of the way in which the NPDB’s business operations are carried out and of the way bills are collected and the budgetary process is managed.

2. In 95 percent of medical malpractice reports reviewed, there was no notice as to whether the standard of patient care had been considered when the claim was settled or adjudicated. I find this disingenuous. Settlement, of course, never notes whether the standard of patient care had been considered or violated. Settlement is about money—the passage of money from one set of hands to another. Is it surprising that these data are not in the NPDB, as there is basically no mechanism by which this process can be achieved?

3. GAO analysis of 252 reports of state licensure actions revealed that approximately 30 percent were submitted late, and 11 percent contained inaccurate or misleading information about the severity and number of times the practitioners had been disciplined. (This problem has to do with the software’s inability to tell whether two reports are about the same episode or for two different episodes; in the example given in the GAO report, it seems clear that the reports were about the same episodes; this indicates operator error as well).

4. There was inaccurate information about one-third of the 79 clinical privilege restriction reports reviewed. In one example given, the practitioner’s privileges were restricted because he failed to fill out medical records. This error in privilege restriction was reported to the NPDB, but as the GAO followed up on delisting, there was no effort to remove the individual from the NPDB.

5. The GAO dealt with underreporting, although the basis of this problem is unclear. It may be that the initial estimates were too high.

6. The GAO was critical of the “corporate shield,” a mechanism by which a corporate entity pays on behalf of a physician so that the physician is never listed. This is something with which the executive committee has been trying to deal for some time. However, the report pointed out that no fine for nonreporting has been levied. Recently, a fine has been proposed and the judicial process begun.

7. Most disturbing to me has been the inability of individuals who have been wrongly listed to get their names out of the repository or to have entries corrected. HRSA appears undisturbed by this predicament. Indeed, the GAO report itself, disappointingly, does not appear to give this too much weight. This, to me, is the most troubling aspect of the NPDB—its lack of responsiveness to the criminalization of medical practitioners. HRSA does not appear to be bothered by the fact that any common criminal can have his/her record corrected easily, but not practitioners in the NPDB. HRSA’s response is that the mechanism in place is satisfactory. Clearly, according to the GAO report, that mechanism is not satisfactory and does not protect the civil rights of physicians. Common criminals incarcerated in a state or federal penitentiary have more civil rights than physicians do at this point in time. The GAO report documents a disturbing instance:

On September 1, 1999, a hospital reported restricting a practitioner’s privileges because of poor record-keeping. The practitioner disputed the report, noting that the hospital planned to monitor his medical records and not restrict his medical privileges. About 1 week later, the hospital attempted to correct the information, requesting that NPDB cancel the initial report. However, in doing so, the hospital incorrectly coded the action as a state license revocation. As of July 2000, when we queried NPDB, the incorrect information on the original restriction and the erroneously reported state licensure revocation were still in the data bank. (GAO report, page 25.)

And another instance:

Our July 2000 query also yielded information on a practitioner that, based on our analysis,

should no longer be available to organizations querying the data bank. In this instance, a state reported revoking a license because the practitioner did not meet its continuing medical education requirements. The practitioner disputed the report and supplied evidence to the state of its error. Although the state reported the mistake to NPDB in February 2000, we received both reports in response to our query, indicating that the information had not been expunged. These reports would likely be of particular concern to the practitioner because this was the only information the NPDB had on this individual. HRSA officials said that while there may be instances where practitioners have difficulty getting reported information corrected, the practitioner notification and dispute resolution process are generally adequate to address most problems. (GAO report, page 25-26.)

Criminalization of medicine

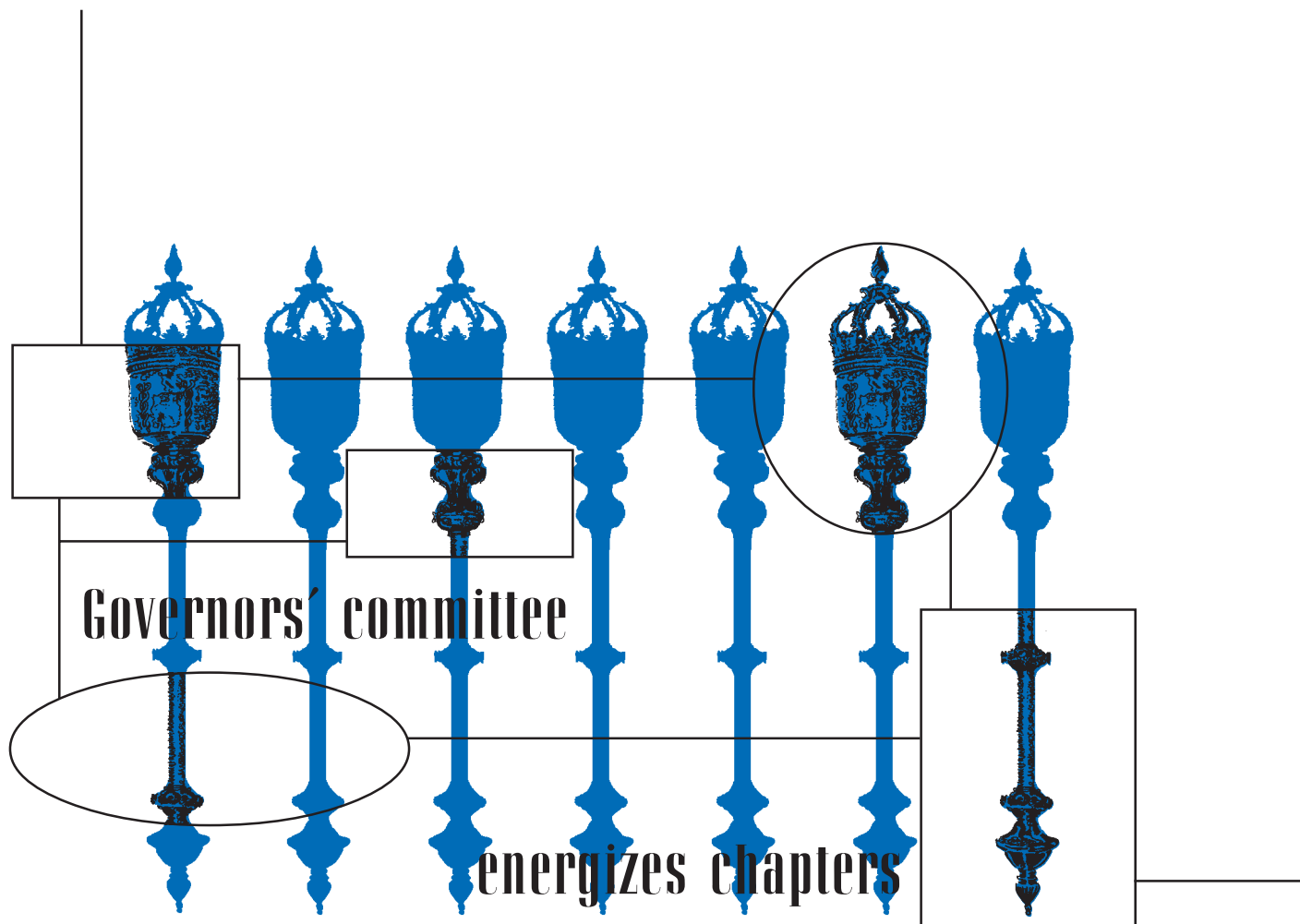
One might think that given the injustice of this particular situation, those community activists who tend to believe in the rights of the patient might also stop and consider for a moment the rights of physicians. They might also consider the result of their well-meaning but unfortunately hopelessly misguided enthusiasm for increasing surveillance and reporting of physicians.

While the NPDB may adequately “police” medical practitioners, the system is terribly flawed and in need of repair. All of us who serve on the NPDB

continued on page 47

Until recently, **Dr. Fischer** was professor and chairman, department of surgery, University of Cincinnati (OH). He is professor of surgery designate, Harvard Medical School, and chairman of surgery designate, Beth Israel Deaconess Medical Center, Boston, MA. He is also a Regent of the College.





by George A. Parker, MD, FACS, Richmond, VA

Editor's note: This article is the fourth in a series highlighting the work of the Board of Governors' committees. It focuses on the Governors' Committee on Chapter Activities.

As Thomas R. Russell, MD, FACS, Executive Director of the American College of Surgeons, noted in a recent "From my perspective" column (*Bulletin*, July 2001), the ACS comprises 99 chapters: 67 in the United States, two in Canada, and 30 throughout the rest of the world. In that same editorial, Dr. Russell observed, "Unfortunately, some chapters are not as active as others. As part of our overall strategic planning initiative, we need to evaluate how these potentially potent forces can be put to their best use—and how the College can help them achieve that goal."

The Governors' Committee on Chapter Activities (GCCA) was created to help chapters become more effective, and we have encouraged Dr. Russell to make improving chapter participation one of the College's priorities over the coming years. This

article provides some background information on the committee's functions and on our plans for the future.

Purposes and organization

The GCCA was established by the College's Board of Governors in 1972. The traditional purposes of this committee have been to help chapters increase their membership and to increase participation in chapter activities by all Fellows, Associate Fellows, and Candidates. Furthermore, the GCCA works to improve communication between chapter members, chapter councils, and the Board of Governors.

A traditional venue for discussion of these matters has been an annual meeting for chapter leaders and administrators. For many years, this event was known as the Chapter Officers' Seminar, but on its 25th anniversary earlier this year, we changed the name of the education program to the Chapter Leadership Conference. We believe this new title better reflects the range of meeting at-

tendees, which include not only chapter officers but council members and chapter administrators as well. Every year, the program centers on a central theme, such as the relationship between the College and the chapters, the evolving role of the chapters, or strategic planning and membership recruitment at the chapter level.

With regard to organization, each of the 19 members of the GCCA serves on a subcommittee that has an agenda aimed at fulfilling the committee's overall objectives. The GCCA's subcommittees are focused on the following issues: chapter meetings and organization; chapter communications; and chapter membership, recruitment, retention, and diversity. The activities that these subcommittees have initiated and implemented through the GCCA as a whole are discussed throughout the remainder of this article.

Developing stronger chapters

The GCCA and its Subcommittee on Meetings and Organization are responsible for identifying a framework for successful chapters—those that encourage more active participation by Fellows in chapter activities and annual meetings. We also seek to pinpoint the characteristics of productive chapter meetings and to communicate this information to the chapters. We further provide new ideas and topics to be presented at chapter meetings that may help unify surgical specialties on topics of broad appeal or that respond to common problems.

To help encourage surgeons, particularly young surgeons, to make a lifelong commitment to the College, two years ago the GCCA completed work on and testing of a scripted Powerpoint® presentation called "About the College." This presentation is designed for use by Governors, chapter officers, and program directors to inform surgical residents and young surgeons about the organization. It describes the history of the College, its past and present activities, and the benefits of Fellowship. We view this presentation as a compilation of evolving materials and intend to continually refine it as the College moves forward. The presentation is available through the College's Chapter Services Office.

To help chapters locate speakers for their scientific meetings, the GCCA also has created a speakers' bureau. The individuals who are part of the

speakers' bureau have been subject to GCCA approval, so chapters that secure speakers through this service are guaranteed to be referred to high-quality presenters. As of press time, the speakers' bureau has received an average of 100 hits per month. The bureau can be accessed through the College's Web site at www.facs.org/speakers_bureau/default.htm with the appropriate password and user name.

Other organization-related activities that we are working on include ensuring that ACS chapter members serve on their respective ACS Committees on Applicants (COAs) and assisting with the College's Advisory Councils.

Over the last few years, GCCA members have expressed concern that, in some cases, COA participants may not be members of their local chapters. The GCCA has been dialoguing with the College's Fellowship Department regarding the application process, and College staff have been working with the Regents' Fellowship Liaison Committee to resolve this issue. In addition, I will be attending a meeting for COA chairs during the Clinical Congress to voice our perspective.

As a final point on chapter organization efforts, the GCCA sends representatives to meetings of the College Advisory Councils to develop recommendations on how the chapters can become more involved in advocacy issues. Based on the suggestions from the Advisory Council Chairs, I believe chapters should be addressing the advocacy needs of all specialties at the state and local levels. These advocacy activities could include: (1) participating in the house of delegates of the state medical societies, and (2) influencing state legislative and regulatory bodies by building coalitions among state/regional specialty societies. The GCCA members agree that chapters should be heavily involved in advocacy activities, and we are in the process of developing guidelines for effective advocacy.

Closer chapter communication

The GCCA and its Subcommittee on Chapter Communications advise chapters on newsletter publication by providing direction and a framework for computer programs, such as desktop publishing. We also assess chapter Web site usage, assist those chapters desiring Web sites, and work to clarify the methodology for Fellow/chapter input to the structure and content of the ACS Web site.

Governors' Committee on Chapter Activities

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The GCCA has very actively promoted the development of chapter Web sites through its Subcommittee on Communications. The tireless work of Robert Inlow, MD, FACS, and Ralph R. Ocampo, MD, FACS, has made it possible for chapter Web sites to be linked with each other and has resulted in 33 chapters now having Web sites. Of these, 12

sites are hosted on the College's Web site, 15 have their own domain names, and six are hosted by a university, medical school, or a commercial provider. The GCCA believes that in the future, managing a Web site should be a core competency for managing a chapter, and we are working with the College's Communications Department to help

chapters become more savvy with regard to developing and maintaining Web sites.

To help clarify the College's standards for chapter Web sites, the GCCA recently developed a document called "Principles Governing Chapter Web Site Content." This document notes that "truthfulness, honesty, integrity, timeliness, clarity of content, and the separation of advertising from editorial content are the hallmarks of a properly managed Chapter Web site." It goes on to provide details about what is acceptable Web site content, linkage to other Web sites, the confidentiality of Web site information, and advertising and sponsorship. This statement can be viewed at www.facs.org/about/chapters/sitecontent.html.

Additionally, the committee is busy exploring various issues related to the use of the Internet in medicine and surgery, including copyright infringement, patient privacy issues, and guidelines for using e-mail to communicate with patients. We have been coordinating these efforts with the Regents' Committee on Informatics.

Bigger, more diverse chapters

The GCCA and its Subcommittee on Membership Recruitment, Retention, and Diversity develop materials and identify successful membership recruitment techniques, acting as resources to chapters on these matters. Further, the GCCA firmly supports Dr. Russell in his efforts to attract surgeons of all specialties and backgrounds to the College and is working to achieve broader representation of all surgeons.

Over the past four years, the Board of Governors and the College as a whole have made tremendous strides in empowering women, due at least in part to improved cooperation with the Association of Women Surgeons. For example, the College recently established a Committee on Women's Issues.

Unfortunately, though, we believe that the College has made less progress in terms of encouraging African-Americans and other minorities to be active members of the College. To test this theory, in 2000, we agreed to survey the College's Fellowship to collect ethnic data. During our April 23, 2001, meeting we went over the results of the survey, which was included in the 2001 dues statement mailing. More than 15,000 Fellows returned the surveys, and, as suspected, the data indicated a lack

of participation among African-American surgeons. The GCCA is working with the College's new ad hoc Committee on Minority Affairs, a brainchild of the GCCA, to address this situation.

To further promote diversity, the GCCA drafted an ACS "Statement on Diversity," which was approved by the Board of Governors at its meeting on October 22, 2000. The statement was then adopted by the Board of Regents at its meeting on June 8-10, 2001, and was published in the August 2001 *Bulletin* (p. 24). This statement highlights the College's commitment "to ensuring pluralism and equal opportunity" within the College through recruitment of underrepresented groups and the appointment of surgeons derived from all groups of members to meaningful leadership positions.

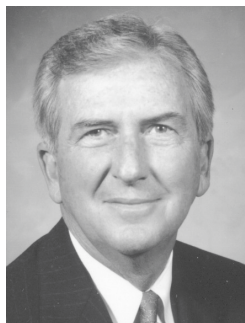
Conclusion

Through all of our activities, the members of the GCCA seek to make the chapters of the College stronger, of greater service to their members, and of more interest to all surgeons throughout the U.S. and the world. As I near the end of my first year as Chair of the GCCA, I would like to thank all of the GCCA members for their dedication to fulfilling our mission, and I look forward to working with them in the future (see roster, p. 27). I also look forward to supporting Dr. Russell and the College's leadership as they work to enhance the posture of the College and stir more interest in this organization. And, finally, I look forward to continuing to represent you and advocating on behalf of all the College's chapters. □

Dr. Parker is clinical professor of surgery, Medical College of Virginia and McGuire Veterans Administration Medical Center, Richmond, VA. He is also an ACS Governor.

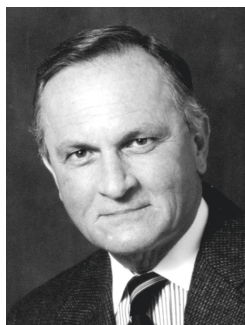
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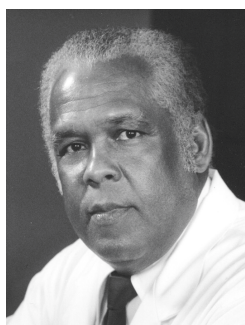
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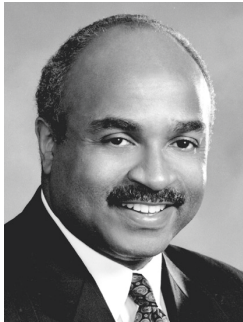


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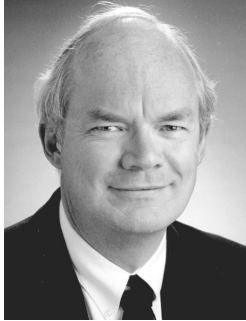
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General surgery
Edward R. Woodard
Professor and chairman,
department of surgery,
University of Florida College
of Medicine
Gainesville, FL

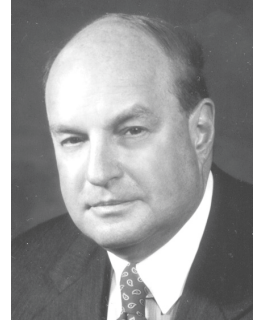


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Gynecologic oncologist,
Mayo Clinic
Rochester, MN



Keeping current

Advances in organ transplantation: The bioartificial liver

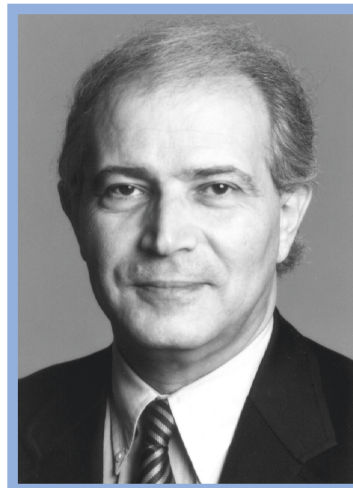
by Adrienne M. Stoller, New York, NY

Editor's note: Achilles A. Demetriou, MD, PhD, is chairman of the department of surgery at Cedars-Sinai Medical Center, where he is also director of the liver support unit. In 1998, Dr. Demetriou was honored as the recipient of the Esther and Mark Schulman Chair in Surgery and Transplantation Medicine. He serves as professor of surgery and vice-chairman of the department of surgery at the University of California, Los Angeles, School of Medicine and is a contributing author for ACS Surgery: Principles and Practice (formerly known as Scientific American® Surgery*). In this interview, Dr. Demetriou discusses hepatic failure and the promise of the bioartificial liver for patients with liver disease.

Q. How is hepatic failure classified and what is the significance for clinical management?

A. The liver is a complex organ that is responsible for innumerable physiologic and biochemical reactions such as synthesis, detoxification, carbohydrate metabolism, temperature regulation, and a host of other processes that are not yet completely understood. It is similar to a power station, providing energy for various parts in the body. When the liver fails, it is a global failure—essentially, the lights go out and thousands of physiologic processes stop. Therefore, it is extremely important to determine the type of liver disease that is present in a patient so that a specific treatment plan can be established.

In general, there are two major forms of liver disease: acute and chronic. Both have a number of etiologies, such as viruses, drug toxicity, mushroom toxins, alcohol, and herbs, among others. Acute or fulminant hepatic failure (FHF) develops in pa-



Dr. Demetriou

tients without preexisting liver disease and no known risk factors. A subgroup of the acute classification is referred to as acute-on-chronic. These patients have chronic liver disease and experience an acute event, such as an infection or bleeding episode, causing further complications and the liver to decompensate. Chronic liver failure occurs as a result of long-standing, ongoing injury to one or more components of the liver. Patients with chronic liver disease and possible cirrhosis are well-compensated and maintain relatively normal functional status.

Q. What are the indications for liver transplantation?

A. The main indication for transplantation is total failure of the liver without hope of regeneration or repair. If a patient's liver fails completely, if we understand the underlying etiology, and if

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spontaneous recovery is impossible, then the patient will need a transplant. Urgent indications for transplantation include significant cerebral edema and brain swelling. A patient who develops very high intracranial pressure is likely to need a liver quickly and must be treated aggressively to bring the pressure under control. Otherwise, the patient is in danger of sustaining irreversible brain damage.

Approximately 4,000 liver transplants are performed annually. Patient survival with liver transplantation is approximately 70 percent. Without transplantation, chances of survival in the most severe forms of liver failure may be as low as 10 percent. Transplantation, therefore, has been the most effective treatment in the management of liver disease and has increased survival tremendously. However, despite the best efforts to manage liver disease of all types, the illness results in about 40,000 deaths in the U.S. each year, and approximately 1,400 patients die while waiting for a liver transplant, often because an organ does not become available.

Q. Which patients should receive transplantation and which should not?

A. At Cedars-Sinai, we see about 150 patients per year with acute and chronic liver failure. Of these patients, about 15 to 20 are severely ill and require urgent transplantation. Surgeons who treat patients with liver disease understand the statistical likelihood of successful transplantation, particularly if there is a preexisting condition. Often we must move very aggressively to make a diagnosis in these patients, within hours if we can. For example, if a patient has Wilson's disease, it is with almost 100 percent certainty that a liver transplant will be necessary. If we can determine the disease entity, we can establish whether a patient will recover spontaneously without a transplant. How aggressive we are in terms of pursuing transplantation is important in the context of the disease, etiology, and patient.

Q. What was the impetus for the development of the bioartificial liver (BAL)?

A. The goal of treatment in the acute setting is to bridge patients either to spontaneous re-

covery or to transplantation. For example, we have found that most patients with acetaminophen-induced liver failure can be supported over a period of days or weeks and can recover spontaneously. The BAL supports these patients through the acute phase of injury, allowing the liver to recover and regenerate. For patients who will not recover spontaneously and who have lost more than 90 percent of their liver mass, the BAL can help prevent brain swelling and sustain life until an organ becomes available for transplantation. In patients who suddenly develop an acute event, the BAL can bring them back down to baseline. So, in patients who require a transplantation, the impetus is to buy time while the patient is living with the disease and until a donor organ becomes available.

Q. How does the BAL support system work and what have been some of the challenges?

A. In some respects, the BAL support system is similar to a kidney dialysis machine in providing long-term support for patients. The device utilizes pig liver cells to process and metabolize waste products. Treatment lasts about six hours. Essentially, treatment with the BAL allows the liver to rest and recover, and in some cases it eliminates the need for transplantation. It provides the patient with stability and prevents injury to the brain. More recently, in experiments with animals treated with the liver support system containing hepatocytes, we found that there was stimulation of the liver's ability to regenerate. Thus, the additional cell mass provided by the BAL system not only provides synthesis and detoxification, but may also promote liver regeneration.

Throughout development of the BAL, we have encountered a number of physiological and developmental challenges. Overall, I believe that a major obstacle is the incomplete understanding of the liver system and the nature of the liver. For example, we do not understand why patients lapse into coma or develop brain swelling in some cases. There are also technical and logistical challenges concerning the BAL, such as engineering, biomaterials, design, cell processing and isolation, purification, immunologic problems of sensitization, possible toxicity, safety, and cost.

Q. What patient groups were enrolled in the clinical study and what have been the initial outcomes?

A. The results from the initial Phase I study were extremely promising, and I believe this trial produced the best survival data in the group of treated patients. The survival results ultimately provided the justification for the recently completed Phase II/III trial. In the original Phase I trial performed at Cedars-Sinai, there were 38 successful treatment outcomes. Of those 38 patients, 32 received transplants and six recovered spontaneously without transplant. Only patients with acute liver failure and no prior chronic liver disease were tested. (An overview of this study can be found in *ACS Surgery* online, Section II, Chapter 7.)

The Phase II/III trial was a pivotal randomized, controlled study consisting of two patient groups: standard of care and standard of care without BAL. About 16 centers in the U.S. and Europe participated in the study, and I hope that this recent trial will show the BAL to be effective in the treatment of liver failure.

Q. In addition to BAL treatment, are there any particular forms of in-hospital support that should be provided to patients with liver failure?

A. At Cedars-Sinai, we take a multidisciplinary approach to the treatment of liver disease. Structured similarly to any intensive care unit, our liver support unit includes key people from each area of clinical practice who are very involved in patient management. The liver support unit contains a research and clinical component; while each key component is independent, they work together as a cohesive team. The research team is responsible for designing and building the next generation of devices, developing new types of cells, and understanding mechanisms. The clinical component con-

sists of surgeons, hepatologists, intensivists, infectious disease specialists, anesthesiologists, and neurologists—essentially various clinical disciplines all working as a unit. As a multidisciplinary team, we pay compulsive attention to detail and work to educate the bedside caregivers in patient management. This system of care has been beneficial for our patients, and I believe it is up to the various teams of physicians throughout the country to develop similar units to increase the chances of survival for patients with liver disease.

Q. What is the primary goal of physicians and caregivers in the management of patients with liver disease?

A. The primary goal is early intervention. Patients with acute or chronic liver failure require supportive care and meticulous attention to detail by a multidisciplinary team. In particular, patients with acute liver disease need to be referred to a major transplant center early so that they can have a greater chance for recovery without requiring a transplant. Even though many patients may never require surgery, it is important for the surgeon to be intimately involved from the beginning, doing a careful evaluation of illness, following response to treatment, and having complete knowledge of the issues.

In closing, it is important to remember that these artificial support systems are experimental. Patients treated with these systems should be enrolled in controlled clinical trials approved by the Food and Drug Administration and with appropriate informed consent. The liver has a remarkable capacity to regenerate itself, and I am confident that this technology will help more patients live longer. □

Log onto www.webmd.com for a complete overview of hepatic failure by Drs. Demetriou and Walid Arnaout in *ACS Surgery: Principles and Practice*. WebMD® is your online source for the latest medical news and topics in surgery.

Ms. Stoller is editor/writer, division of physician communication, WebMD, New York, NY.

Socioeconomic tips of the month

Filing Medicare claims

This month's column focuses on several changes surgeons need to be aware of when filing Medicare claims for their patients. First, a few brief announcements:

- In June 2001, the Health Care Financing Administration (HCFA) became the Centers for Medicare & Medicaid Services (CMS). The name change should not affect the way physicians now submit claims for Medicare services.
- To aid Fellows in keeping track of real changes in coding and Medicare, we are introducing "Around the corner," a calendar of upcoming dates when coding and fee schedule updates are scheduled. We will also note the availability of ACS coding workshops. This new addition to "Tips" appears for the first time in the box at right.

Requirements for preoperative services

In an effort to standardize policies that some Part B carriers have instituted, CMS has established a national policy on preoperative services. All claims for preoperative medical examination and preoperative diagnostic tests must be accompanied by the appropriate ICD-9 V code for preoperative examination. The descriptions of the V codes are as follows:

- V72.81 Preoperative cardiovascular examination
- V72.82 Preoperative respiratory examination
- V72.83 Other specified preoperative examination
- V72.84 Preoperative examination, unspecified

The ICD-9 code that appears in the line item of a preoperative examination or diagnostic test must be the V code for the appropriate preoperative examination.

In addition, the appropriate ICD-9 code for the condition(s) that prompted surgery must be documented on the claim. Other diagnoses and conditions affecting the patient should also be documented on the claim, if appropriate. Claims for preoperative services are still subject to carrier

Around the corner

October

- 2002 ICD-9-CM code changes effective October 1. The 90-day implementation period during which Medicare will allow claims to be submitted with the 2001 and the 2002 ICD-9-CM code versions begins.
- Quarterly update to 2001 Medicare fee schedule effective October 1.
- Quarterly update to 2001 *Correct Coding Edits* effective October 1.

November

- 2002 Medicare fee schedule due for release.
- ACS-sponsored advanced coding workshop for surgeons at the Eastern Pennsylvania chapter meeting on November 1, 2001. Contact Irene Dworakowski at 202/672-1507 or e-mail Idworakowski@facs.org to register.

review for medical necessity.

This policy change became effective January 1, and Part B carriers were instructed to change their edits by June 30. If a claim for preoperative examination during the January-June period was rejected, resubmit the claim with the appropriate V code.

Revised remittance advice remarks

Another step has been taken to fulfill some of the requirements of the administrative simplification provisions of the Health Information Portability and Accessibility Act of 1996 (HIPAA).

An update to the American National Standards Institute Insurance (ANSI X12N) remark codes for provider remittance advice (Standard 835) became effective for Medicare on October 1, 2001. Changes include requirements to: (1) electronically void and correct claim history when adjusting a claim, rather than simply posting differences in payment; (2) to identify the primary payor if denying a claim because Medicare is not primary; and (3) to identify any secondary payor with whom benefits are coordinated.

continued on page 41

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College news

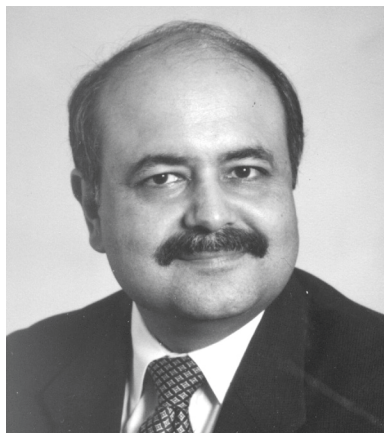
New members join ACS executive staff

ACS Executive Director Thomas R. Russell, MD, FACS, recently announced two new appointments to the executive staff of the College. Ajit K. Sachdeva, MD, FACS, FRCSC, will become Director of the Division of Education in September 2001, and David P. Winchester, MD, FACS, became the Medical Director of Cancer programs on August 1, 2001.

Dr. Sachdeva comes to the College from Philadelphia, PA, where he spent 21 years on the faculty at the MCP Hahnemann School of Medicine/Medical College of Pennsylvania, most recently serving as the Leon C. Sunstein, Jr., Professor of Medical and Health Sciences Education, professor and vice-chairman for educational affairs, department of surgery, and director and chief, division of surgical education.

A Fellow since 1983, Dr. Sachdeva has been a member of the Board of Governors since 1996. He is a member of the Governors' Committee on Physician Competency and Professional Liability, and he has served on the College's Committee on Surgical Education in Medical Schools and the Committee on Continuing Education. He also is a member of the faculty for the College's Surgeons as Educators Course and has delivered a number of presentations at the annual Clinical Congress.

Dr. Sachdeva obtained his medical degree in 1974 from the All-India Institute of Medical Sciences, New Delhi. He was a



Dr. Sachdeva



Dr. Winchester

resident in general surgery at the Hospital of the Medical College of Pennsylvania in Philadelphia from 1975 to 1980. His academic appointments at the MCP Hahnemann School of Medicine/Medical College of Pennsylvania have included instructor in surgery (1980-1982), assistant professor of surgery (1982-1987), associate professor of surgery (1987-1995), professor of surgery (1995-2001), and Leon C. Sunstein, Jr., Professor of Medical and Health Sciences Education (1997-2001). He also served as associate dean for medical education at the MCP Hahnemann School of Medicine (1994-1998).

Dr. Sachdeva served as chief of surgical services at the Philadelphia Veterans Affairs Medical Center for over eight years, during which time he planned and directed the expansion of tertiary care services staffed by two

medical schools (the University of Pennsylvania School of Medicine and the MCP Hahnemann School of Medicine). He established a regional network health care program for women veterans to provide a complete range of primary, secondary, and tertiary care to women. Dr. Sachdeva received recognition for this highly acclaimed model through the award of a gold medal in the Excellence in Government Awards Program and the National Performance Review Award of the Vice-President of the United States.

Dr. Sachdeva was awarded the Lifetime Achievement Master Educator Award by the Association for Surgical Education in 1997. He has received the Lindback Award for Distinguished Teaching, the Blockley-Osler Award for Excellence in Clinical Teaching, and several Golden Apple Awards for teach-

ing excellence. Dr. Sachdeva is a member of the Alpha Omega Alpha Honor Medical Society. He has conducted over 145 national and international courses and workshops on education and has delivered presentations on educational topics in the United States, Canada, Europe, Australia, and Japan.

He has chaired the Committee on Surgical Education of The Society of University Surgeons and is chairman of the Scientific Review Group Education Subcommittee (Study Section) of the National Cancer Institute, National Institutes of Health. Dr. Sachdeva also serves as a representative of the Council of Medical Specialty Societies to the Accreditation Council for Continuing Medical Education. He has been the recipient of a number of major educational grants and has published widely in peer-reviewed journals on a variety of educational topics.

Dr. Sachdeva has served as president of the Association for Surgical Education, the American Association for Cancer Education, and the Alliance for Clinical Education—an umbrella body of national organizations of clerkship directors from various medical disciplines.

Dr. Winchester previously served as Medical Director of the College's cancer activities from 1985 through 1998. He will again assume the duties of Medical Director while continuing his practice and serving as chairman, department of surgery, Evanston/Northwestern Healthcare, Evanston, IL.

A Fellow since 1974, Dr. Winchester has been an active member of the Commission on Can-

cer, serving as Midwest and State Chairman of the Field Liaison Program, member of the Approvals Committee, and member of the Cancer Management Course Committee.

Dr. Winchester received his medical degree in 1963 from Northwestern University Medical School, Chicago, IL. He completed a surgical residency at Northwestern, where, under the guidance of Edward F. Scanlon, MD, FACS, he was encouraged to pursue a career in cancer care.

In 1970, Dr. Winchester went to M. D. Anderson Hospital and Tumor Institute in Houston, TX, to complete his fellowship training and became a faculty associate. In 1971, he became an associate in surgery at Northwestern and assistant attending surgeon at Evanston Hospital. He has served as professor of surgery at Northwestern University Medical School since

1992, and as associate dean for medical affairs at the university since 2000.

Dr. Winchester has served as executive director of the American Joint Committee on Cancer (1992-1998), president of the Society of Surgical Oncology (1997-1998), and president, Illinois Division, American Cancer Society (1986-1988), and has received an honorary fellowship from the American College of Radiology. In addition, he has served on the editorial boards of numerous cancer-related publications, including *Surgical Oncology*, *Annals of Surgical Oncology*, *Journal of Surgical Oncology*, *International Journal of Radiation Oncology, Biology and Physics*, and the *Journal of Clinical Oncology*. He also has served as an ad hoc reviewer for the *New England Journal of Medicine*, *Archives of Surgery*, and the *Journal of the American College of Surgeons*.

OFFICIAL NOTICE

Annual Meeting of Fellows, American College of Surgeons

In accordance with Article I, Section 3, of the *Bylaws*, the Annual Meeting of the American College of Surgeons is called for four o'clock in the afternoon of Thursday, October 11, 2001, in the Ernest N. Morial Convention Center, New Orleans, LA.

This session constitutes the annual business meeting of the Fellows, at which time officers

and Governors will be elected, and reports from officials will be presented. Items of general interest to the Fellows will also be presented. Each Fellow is respectfully urged to be present.

Kathryn D. Anderson, MD, FACS
Secretary,
American College of Surgeons
August 15, 2001

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Congress exhibit to track effects of aging on cognitive performance

by Lazar J. Greenfield, MD, FACS, Ann Arbor, MI

An exhibit at this year's Clinical Congress in New Orleans, LA, will afford surgeons the opportunity to participate in a research project that seeks to measure the effects of aging on cognitive performance.

It is an inescapable fact of life that the price of continuing to celebrate birthdays is the physiological decline we attribute to aging. For a surgeon, the penalty of slowed reaction time is not nearly as dramatic as it is for a professional boxer. However, the present climate of increasing concern for patient safety, avoidance of medical errors, and assurance of quality outcomes places a burden of proof on the surgical profession to confirm the safe performance of surgeons as they age. Looking around at our colleagues it seems clear that there is considerable variation in the rate and character of these changes.

Several years ago, we conducted a small study of volunteer faculty to measure their cognitive functioning and some motor skills using a computerized instrument called MicroCog, which had been validated previously in nonsurgical physicians.* The test measures reactivity, attention, verbal memory, visuospatial facility,



The author (right) taking the MicroCog examination.

reasoning, and mental calculation. The average age of surgeons tested was 56 years, and they scored in the predicted range for their age. We repeated the test five years later and found no significant declines in overall cognitive performance, though there was an age-related decrease in speed of cognitive processing.† None of the changes correlated with a surgeon's decision to retire, which seemed to correlate primarily with reaching a specified age.

† O'Neill J, Bieliauskas L, Steinberg B, Greenfield L: A longitudinal study of cognitive test performance and retirement in aging surgeons (abstract). *J Int Neuropsychol Soc*, 7:227, 2001.

The lack of a measurable decline in cognitive performance could be due to better preservation in surgeons to which we are certainly entitled, or, more likely, the test is not sufficiently sensitive to detect subtle changes in this population. But does it really matter? Why should we go to such trouble to measure cognitive performance and reaction times in surgeons? The answers seem clear to this observer. We simply have no basis for making judgments about our own performance on important issues like retirement.

Rather than select an arbitrary age, why not allow competent surgeons to continue active practice until there is evi-

* Powell D: *MicroCog: Assessment of Cognitive Functioning*. San Antonio, TX: The Psychological Corp., 1993.

dence that deterioration has occurred? Of more concern, if we fail to provide assurances to the public, how can we defend against an attempt to legislate a solution? After all, senior drivers must pass examinations to continue to drive; why should surgeons be exempt from any measurement of declining performance? If we fall back on peer review and outcomes assessment, the criticism is that bad outcomes must occur before a change is recommended, and there are many examples of legal tactics that allow surgeons to continue to operate despite evidence that they should stop.

And what about the medicolegal liabilities of such tests if they were available to plaintiff's attorneys? One solution to that problem is to make the results available only to the surgeon's personal physician, which would mean they would be protected.

If we assume that such information would be of value, how can we accumulate sufficient data to provide a reference database for all ages?

The American College of Surgeons has supported the

concept of a pilot project to collect data during this year's Clinical Congress. A new instrument developed for research on cognitive changes with aging will be available for our use. It is the Cambridge Neuropsychological Test Automated Battery (CANTAB), which is computer-administered and has been normed on over 3,000 patients and controls. It has been found to be particularly sensitive to cognitive changes even when more traditional tests failed to detect them. It uses a touch-screen method that is language-free, making it particularly suitable for potentially noisy environments. We plan to use a screened booth in the scientific exhibit area to avoid visual distractions as well as ear protectors to minimize noise.

Having taken both the MicroCog and CANTAB tests (see photo, p. 40), I can attest to the value of the CANTAB, which takes only 20 minutes to complete, as opposed to the 45 minutes required to complete the MicroCog. The CANTAB test also moves easily from very easy items into more complex

ones that are truly challenging but fun.

This year's Congress attendees are encouraged to stop by the booth in the scientific exhibit area of the Ernest N. Morial Convention Center to see the display and talk with the faculty who will be there to administer the test. All data will be recorded by code, and the name of the volunteers, along with their linked code, will be kept secure and separate from the test data, which will have only a numerical code identifier. Test results will be sent to the participant's personal physician if so desired.

In five years, all participants will be recontacted and encouraged to repeat the test at that time. As "cognitive" surgeons, we will be able to state that we are paying as much attention to the determination of our exit from the profession as to the requirements for admission.

***Dr. Greenfield** is Frederick A. Collier Distinguished Professor and chairman, department of surgery, University of Michigan, Ann Arbor. He is First Vice-President of the College.*

SOCIOECONOMIC TIPS, from page 36

The remark codes appear on remittance advice received by physicians. The codes are maintained by CMS, but because HIPAA applies to virtually all U.S. health care payors, expect other payors to begin using the codes as well.

Part B carriers are distributing the remittance advice codes via provider bulletins. Most carriers post their bulletins on their Web sites. If you would like to view the codes on the Washington Publishing Company (WPC) Web site, go to www.wpc-di.com, and select "Guides," "Insurance," "Health

Care Code Lists," and "Remittance Advice Remark Codes" on each successive Web page. 

This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or e-mail HealthPolicyAdvocacy@facs.org.



Letters...

The following comments were received via e-mail regarding "From my perspective" columns written recently by ACS Executive Director Thomas R. Russell, MD, FACS.

Careers in surgery

Thank you for your recent editorial in the *Bulletin* (June 2001). You have voiced very accurately the concerns that I have had for several years now. Each and every one of your observations is correct and on target.

I believe that there is another factor that also leads medical students away from surgical specialties. That factor is the strong desire for a personal and family life. I have noted in our residents a much stronger commitment to family than to patients. That's not to say they aren't committed to the patients; they are. But they are more committed to their families. Unlike so many of our generation, who have sacrificed self and family, they feel that when they are off, they are off. They feel family time is more valuable than after-hours patient care, after all, that can be done by others. I am not saying that this is bad, just that it is different.

If you look at the incidences of divorce and drug and alcohol abuse among our generation of physicians, maybe they are right. We have given everything to our patients. The patient has always come first, even before ourselves and our families. We are fulfilled and rewarded by our giving and healing. I sense that this philosophy is slowly changing. Among the residents who have chosen surgery, the strong trend toward family is ever-

present. Even the proposed OSHA changes outlined in this *Bulletin* support less work and more leisure time for housestaff.

Again, I am not saying these changes are good or bad—just that change is definitely replacing older traditional values in these young physicians and the patients will not know how to accept it.

E. D. Deloach, MD, FACS

I read with interest your column in the June *Bulletin*. The current status of the unattractiveness of general surgery was predicted by some surgical educators decades ago. It has taken a while for the predictions to come true. The readily observable trend of the development of "general surgery" area specialists had clearly begun in the mid-1970s, and has since accelerated. Many faculty in departments of general surgery were de facto superspecialists—that is, transplant, endocrine, breast, hepatobiliary, trauma, and so forth, in addition to the approved subspecialists of pediatric, vascular, and hand. Critical care was later developed as well. These areas have certificates of additional competence or specialty status. There were some members of the residency review committee (RRC) who initiated the concept of "tracking" in such special areas as mentioned above in the fifth year of general surgical training. Unfortunately, those enlightened members of the RRC who proposed that general surgical training be modified to allow tracking with a mostly elective fifth year for specialization in areas a trainee might find desirable (including

more broad training in general surgery) ran into the incredible opposition of several members of the American Board of Surgery. The so-called anti-fragmentation group was vocal and politically savvy and expended great emotional effort to defeat the efforts of tracking. The culmination of the defeat of a more flexible general surgery residency was a position statement by the board that there would never be any additional certificates of additional competency that would be contributory to "fragmentation." Those same opponents, as well as practicing general surgeons, have ironically been part of the exodus from the profession of operating general surgeons. Observe the declining age of retirement of general surgeons, now reported to be below 60.

In the same issue of the *Bulletin* is a promise of help, found in the article authored by Robert S. Rhodes, MD, FACS. It may be the societal demand for outcome measure that has now been adopted by the Accreditation Council for Graduate Medical Education that resurrects the concept of tracking within general surgery residencies. I believe tracking would be superior to the unapproved fellowships that are the current status quo. This change to allow tracking with subsequent accompanying certification, I believe, would have appeal to some of the "best and brightest."

James T. Evans, MD, FACS

College chapters

As always, I enjoyed your column about the College's chapters (July 2001). I have always

been an advocate of a stronger chapter participation in the affairs of the College. Perhaps if individual chapter members had the opportunity to elect their national leadership (Governors and Regents) rather than have them appointed by a council, they would perceive that they had more of voice in chapter and College functions. I can speak only from experience in my chapter (North Texas). Other chapters may actually elect the Governors from membership nominated candidates; I don't know. In addition, the College should look to the chapters for members of national College committees.

I don't know how members of committees are chosen, but I can remember, years ago, trying to get on the ACS Committee on Operating Room Environment and having my request completely ignored. The chapter member needs to know that his or her work and interest at the "grassroots level" will be meaningful.

Also, smaller chapters should be combined geographically for CME meeting purposes or grouped with nearby larger chapters for the same. These are just some spontaneous thoughts on the subject. If they are already in place, then please forgive my ignorance.

Robert Turner, MD, FACS

Nonphysician providers

I have written to you previously on this subject and appreciate your original comments. I routinely read your comments in the *ACS Bulletin*. Do you plan on addressing nonphysician providers' role in health care to-

day? What are your thoughts, as an experienced surgeon and physician, as to the freedom and lack of supervision seen in many of today's community and university institutions?

As a resident, I see daily how much latitude physician's assistants (PAs)/nurse-practitioners (NPs) are given with regard to admitting/discharge/prescription rights and their recent proclamation for legally unsupervised practice. Even as a surgeon this situation worries me. It seems to me that, if granted to family practice/internal medicine arenas, the next step would be outpatient surgery and other surgical procedures (endoscopy/bronchoscopy, and so forth). This would affect my practice in the future. I see this as competition from an inferior source, not to mention dangerous. With HMOs and insurance carriers looking for the monetary "bottom line" it is logical that they would preferentially hire PA/NPs rather than a physician to do the same work.

Case in point: nurse anesthetists (NAs). They are now polling for independence, and will get it (if they already haven't in some states). As a result, institutions and insurance plans will hire three NAs rather than one anesthesiologist for the same price. It makes fiscal sense. Many NAs believe that they are qualified to do the same work as the physician and are quite vocal. Currently, there has been little backlash from anesthesiologists because there is such a shortage of physicians in that field. Wait five to 10 years: there will be essentially no physicians staffing the ventilator in the op-

erating rooms. The rest of medicine is no different. People who think that it is, I believe, are burying their heads in the sand and ignoring a potentially career-ending problem.

It begs the question once asked of me by a PA: "Why go to school for all those years, lose the earning capacity, and be relegated to call for the rest of your life? We (PAs) can go to school for one-third the time, start at \$60,000, have no loans, and do in essence most of the work without any of the call and responsibilities. After all, that is what a doctor is for; let them call the physician for all of the problems!"

**Brian Bansidhar, DO,
ACS Candidate Group**

Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its meeting on February 9, 2001:

- The Board expelled Teofilo Po, a general surgeon currently residing in Hacienda Heights, CA. His license to practice medicine in the state of California was suspended on July 19, 2000, based upon his conviction for mail fraud and subsequent incarceration in federal prison.

- The Board expelled Robert E. Farner, Jr., a colon and rectal surgeon from Dallas, TX. Dr. Farner was convicted of Internet solicitation in 2000 and incarcerated in federal prison.

The following disciplinary actions were taken by the Board of Regents at its meeting on June 9, 2001:

- The Board expelled George Chung, a retired thoracic surgeon from Eugene, OR. Dr. Chung's license to practice medicine was revoked by the Oregon Board of Medical Examiners in 1998 based upon a 1997 felony conviction for attempted sexual abuse of a minor.

- The Board suspended Frank J. O'Connor, Jr., a retired urologist from Virginia Beach, VA. Dr. O'Connor's license to practice medicine in the state of Virginia was placed on indefinite probation with terms and conditions in 1999 resulting from several incidents in which he failed to properly document treatment, made diagnostic and treatment errors, and failed to address patient complaints.

- The Board placed a urolo-

gist from West Orange, NJ, on probation for a period of time to run concurrently with his probationary status in the State of New Jersey. In 2000, the New Jersey Board of Medical Examiners ordered this surgeon's license to practice medicine and surgery suspended for two years, with one month active and the remainder to be served as probation as a result of sexual misconduct, inappropriate prescribing, and poor record keeping.

- The Board placed a general surgeon from Meadville, PA, on probation for a period of time to run concurrently with his medical license probation in the States of Ohio, Pennsylvania, New Jersey, and New York. The surgeon's license was placed on probation by the Ohio Medical Board in 1999 based on his failure to maintain medical records concerning controlled substance prescriptions issued to his wife. His probationary status in the states of Pennsylvania, New Jersey, and New York are based upon the Ohio action.

- The Board placed a general surgeon from Portland, OR, on probation for a period of time to run concurrently with his medical license probation in Oregon; until such time as he has full and unrestricted surgical privileges in an accredited hospital; and until his practice pattern has been reviewed and approved by the Central Judiciary Committee (CJC). This surgeon's license was restricted by the state of Oregon and his surgical privileges

were limited by the Kaiser Foundation, resulting from four patient cases involving adverse outcomes, three of which included the death of the patient.

- The Board restored the Fellowship of a general surgeon from Plano, TX, who had been placed on probation by the Board in 1997. This surgeon was originally placed on probation by the College after the Texas Medical Board had placed his license on probation for five years with terms and conditions resulting from an arrest for driving while intoxicated in 1995. In May of 1999 the Texas State Board of Medicine restored this surgeon's license status to full and unrestricted. After review of the actions taken by the State of Texas as well as the surgeon's current practice status, the CJC recommended to the Board that restoration of full ACS Fellowship be made.

Liability and patient safety issues to be addressed at Congress

With major changes occurring in health care, it is important for physicians to become aware of new areas of physician liability brought about by business/professional arrangements being made with a wide variety of health care organizations. The ACS Regents' Committee on Patient Safety and Professional Liability is sponsoring three sessions at the 2001 Clinical Congress in New Orleans, LA, to address current liability issues: Postgraduate (PG) Course No. 1, Physician Liability in a Changing Health Care Environment, and two panel discussions entitled The Surgeon and the Law, and Patient Safety in Surgery: From Basic Science to Bedside.

PG No. 1, Physician Liability in a Changing Health Care Environment, will be held Sunday, October 7, 1:00-5:00 pm. The co-chairs for the course are Susan H. Adelman, MD, FACS, Detroit, MI, and F. Dean Griffen, MD, FACS, Shreveport, LA.

The objectives of this course are to review the new areas of physician liability that occur in the managed care era, including contract liability, delay of care, and denial of care, as well as to identify the traditional high-risk areas of surgical practice and the importance of careful documentation in the medical record. In addition, a road map to the legal system and the perspectives of plaintiff and defense attorneys will be offered to diminish anxiety



Dr. Adelman



Dr. Griffen



Dr. McArthur



Dr. Kern

ety about unknowns in the legal process. Methods available to deal with these risks will be discussed, including the systems approach to error prevention. Proactive advice will be given on how to avoid a lawsuit, how to proceed when one is sued, and how to protect one's mental

health during this process.

Upon completion, participants will have learned about new areas of physician liability as well as traditional high-risk areas of surgical practice. Patient safety, risk management, and risk prevention will be emphasized. Participants

will learn about the legal process and its psychological impact, depositions, and courtroom strategies.

Panel Discussion: The Surgeon and the Law will take place Tuesday, October 9, 8:00-10:00 am. Michael McArthur, MD, FACS, Tyler, TX, will serve as moderator for the discussion. The panel will address the issue of holding HMOs accountable and the "Texas experience." Panelists include George Young, Robert Provan, and Donald Wilcox. Mr. Young will address the current status of the Texas HMO liability statute and strategies to avoid being joined in lawsuits because of HMO misconduct. Mr. Provan will discuss

class-action lawsuits by Texas, other state medical societies, and individual physicians against HMOs and PPOs for violation of state and federal laws. Mr. Wilcox will review the challenges to physicians in providing high-quality care under the restrictions imposed by for-profit managed care companies.

Panel Discussion: Patient Safety in Surgery: From Basic Science to Bedside will be held Wednesday, October 10, 1:30-3:30 pm. Kenneth A. Kern, MD, FACS, Hartford, CT, will serve as moderator for the session.

Attendees will be introduced to: (1) the epidemiology of error in surgical patients, (2) the basic science of understanding

human and system errors, (3) practical approaches to identifying and reducing preventable errors in surgery, and (4) regulatory efforts to track progress in medical error reduction.

Panelists and their topics are: Atul Gawande, MD, Boston, MA, Epidemiology of Errors in Surgery; Richard I. Cook, MD, Chicago, IL, Human Factors and Cognitive Approaches to Error Prevention in Surgery; J. Forrest Calland, MD, Charlottesville, VA, Error Reduction in Laparoscopic Cholecystectomy and Multistep Surgery; and Bryan A. Liang, MD, PhD, JD, Carbondale, IL, the Federal Regulatory Role in Patient Safety.

At Clinical Congress

CESTE to feature exhibit on surgical simulators

The ACS Committee on Emerging Surgical Technology (CESTE) will present an exhibit of The State of the Art in Surgical Simulation at the 2001 Clinical Congress in New Orleans, LA. The exhibit, first presented in 1999 in Orlando, FL, provides surgeons with an opportunity to use the surgical simulators and to experience their capabilities. Emerging simulation technol-

ogy from government and academic laboratories will be on display.

One of the laparoscopic simulators, the MIST-VR, will be of special interest to experienced laparoscopic surgeons. At this station, surgeons with experience in more than 50 laparoscopic procedures will be asked to test their skills in the MIST-VR and in a standard box

trainer, in order to develop baseline data of basic skills performance that can be used to determine minimal criteria for skills training.

The exhibit will be located in the scientific exhibit area of the Ernest N. Morial Convention Center. All interested surgeons, residents, and students are invited to visit the exhibit and test their skills.

NPDB, from page 24

executive committee anticipate that HRSA will become more attentive to the concerns of the health care community and, as a result, make the data in the NPDB more useful and meaningful. Under the current circumstances, the NPDB fails to benefit physicians, other providers, and patients. □

This article was generated through efforts of the Committee on Patient Safety and Professional Liability of the ACS Board of Regents. Members of the committee believe this and other articles published in the *Bulletin* will stimulate thought and possible action on a wider range of issues related to patient safety and professional liability.

Dues structure to be reviewed

In 1971, the ACS Board of Regents appointed the Board of Governors' Committee to Study the Fiscal Affairs of the College. The purpose of the committee was to study the amount of a potential dues increase and the manner in which it would be collected, as well as other possible means of increasing the income of the College. The following year, the Board of Regents decided to continue the committee, which currently meets three times a year. The Fiscal Affairs Committee provides an important link to both the Board of Governors and to the Fellowship.

The committee met August 30, 2001, to review the 2002 budget and business plans for new pro-

gram initiatives. In addition, the committee reviewed and discussed the College's "Strategic Plan" with Executive Director Thomas R. Russell, MD, FACS. The plan identifies four focus activity areas that will drive the organizational structure, goals, and objectives of the College. Dr. Russell discussed initiatives that are currently in development or that were recently approved by the Board of Regents and their related costs. The strategic planning process also involved an examination of existing College programs, the classification of programs as being dues-supported or revenue-producing, the consumption of resources by each program or program area, and the average dues per mem-

ber against the cost of dues-supported programs.

The committee also reviewed the dues history of the College, a comparison of College dues against other organizations, and the impact of inflation on the purchasing power of a dues dollar since the last increase in 1991. Armed with this information, the Fiscal Affairs Committee will make a dues structure recommendation to the College's Finance Committee. The Fiscal Affairs Committee will then review feedback from the Finance Committee and comments from Fellows and recommend a dues structure to the Board of Governors at the meeting in New Orleans, LA, on Sunday, October 7, 2001.

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Highlights of the Board of Regents meeting

June 8-10, 2001

by John P. Lynch,
Director,
Organization Department

The June Board of Regents meeting consisted of the traditional business meeting and two days of special sessions designed to frame a strategic plan for the College and to approve an internal reorganization structure that will enable staff to proceed with its implementation. This article reviews both parts of the meeting, first outlining the actions taken during the traditional meeting, and then highlighting the major results of the strategic planning sessions.

Financial reports

The Regents approved the 2002 budget prepared for the 12 months ending June 30, 2002, representing the first full year since the change in fiscal year end from the previous calendar year-end budget. The budget includes discretionary provisions for new College programs, provisions for strategic planning activities, competency activities, and the second phase of the Board of Governors' (B/G) "Volunteerism and Giving Back to Society Among Surgeons" pro bono program.

In other financial matters, the Regents approved the audited financial statements of the American College of Surgeons as of December 31, 2000, and for the year then ended, including the independent auditors report of the firm Deloitte & Touche, LLP. The Regents also approved transaction approval levels and a purchasing policy, a Board of Regents conflict of interest policy, and a misconduct in science policy.

Working Group on Archives and Properties

The Board of Regents approved a recommendation from its Working Group on Archives and Properties to select a vendor, Deloitte & Touche, LLP (includes a subcontract with Skidmore, Owings & Merrill, LLP),

to evaluate the potential use and financial impact of the use of the College properties at 50 E. Erie (the Murphy Memorial Auditorium), and 40 E. Erie (the Nickerson Mansion) in Chicago, IL.

Clinical Congress dates

The Regents approved date changes for the 2006 Clinical Congress in Chicago to October 8-13, and for the 2009 Clinical Congress in Chicago to October 11-16.

"Giving back" project

The second phase of the B/G Giving Back to Society pro bono project was approved by the Regents. The project, coordinated by the B/G Committee on Socioeconomic Issues, will include a *Bulletin* article on giving back with a tear-off reply card for Fellows to report their volunteer activities, a follow-up survey of respondents to begin developing a database of volunteer activities, interviews with selected Fellows at the Clinical Congress, panels and postgraduate courses on volunteerism at future Clinical Congresses, efforts to identify and reduce legal and personal barriers to volunteer activities among surgeons, and endeavors to promote linkages with organizations such as Volunteers in Health Care.

Statement on Diversity

The Regents approved a revised ACS Statement on Diversity developed by the B/G Committee on Chapter Activities and approved by the Board of Governors at its meeting on October 22, 2001. The statement was published in the August 2001 issue of the *Bulletin* (p. 24).

Establishing a 501(c)(6) organization

The Board of Regents approved the recommendation from the Health Policy Steering Committee to establish a task force to make

the necessary plans to form a 501(c)(6) organization for the purpose of enhancing the College's legislative advocacy program and disseminating its health policy agenda. The committee in making this recommendation emphasized that:

- The College should retain its 501(c)(3) status (organized for charitable, educational, and research purposes).
- The new, separate 501(c)(6) entity should be considered a potential "umbrella" organization that will enhance the representation of all surgical specialties.
- Any program established under the 501(c)(6) may be used to support specialty-specific issues on occasion, as long as they do not conflict with the interests of surgery as a whole.
- The 501(c)(6) should form the basis of a more comprehensive legislative support program for use in fostering constructive personal relationships between Fellows and their legislators.

The task force report suggesting the model for forming a 501(c)(6) organization will be presented to the Board of Regents for consideration at its meeting in October.

Proposed partnership with VA

The Regents reviewed a proposal for a partnership between the U.S. Department of Veterans Affairs (VA) and the College to establish a combined VA and non-VA National Surgical Quality Improvement Program (NSQIP). The VA has developed, implemented, conducted and supported a national data collection and feedback system of risk-adjusted surgical outcomes for the purpose of continuous quality improvement in its surgical service for the past 10 years. Coincident with this program has been a 43 percent reduction in 30-day postoperative morbidity and a 28 percent reduction in 30-day postoperative mortality in the VA system. The ACS-VA partnership would facilitate the sharing of the NSQIP methodology with the private health care sector in the U.S., thereby providing leadership to the national surgical community in devel-

oping a surgical quality improvement program to improve patient outcomes throughout the U.S.

Under the agreement, the ACS would endorse the use of the NSQIP by non-VA medical centers and their surgery departments, provide members for the board of directors of the NSQIP, commit to pursuing with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) establishing the NSQIP risk-adjusted outcomes as performance measures for surgery, and provide financial support for NSQIP expansion. Among the VA's responsibilities would be provision of the conceptual foundation of the intellectual property of the NSQIP. This would include the statistical and computational foundation of the NSQIP, as well as the organizational practices developed for data collection, analysis, and feedback of findings to medical centers. The VA also would provide the core database of over one million major surgical cases from which the expected outcomes model has been developed, refined, and validated.

The College has submitted a grant proposal to the Agency for Health Care and Research Quality, to further study the effect of the NSQIP program in nonfederal hospitals. The Regents approved the recommendation of their Finance Committee to further examine the NSQIP program and the College's relation to it. There was very positive discussion among the Regents concerning the merits of this program, and the proposal will be reviewed again at the October meeting of the Board of Regents.

Information reports

The Board considered several information reports prior to the strategic planning meeting. These included reports from several committees, such as the Regents' Committee on Ethics, the Board of Regents' Executive Committee, the Committee on Young Surgeons, the Graduate Medical Education Committee, the Committee on Women's Issues, the Committee on Emerging Surgical Technology and Education, the Health Policy Steering Com-

mittee, and the Committee on Patient Safety and Professional Liability. Organization reports were presented from the JCAHO and the Council of Medical Specialty Societies. Staff reports regarding the 2001 Chapter Leadership Conference, federal legislative and regulatory activities, the *Journal of the American College of Surgeons*, cancer, trauma, communications, and informatics activities, and the development program were also presented.

Strategic planning meeting

The two-day strategic planning meeting featured: a review of the ACS strategic plan; consideration of the internal reorganization staffing structure to carry out the plan; a review of the results of the member survey titled "Needs, Participation, Attitudes, and Assessment: The 2001 Study of Fellows"; four work group reports; a presentation on assessing the health care environment; reports from four break-out sessions; and business plan presentations on the National Trauma Data Bank, Office of Evidence-Based Surgery, and a national marketing/branding program.

Ultimately, the Regents approved the "American College of Surgeons Strategic Plan" (see page 9), which encompasses a mission, a vision, a primary focus, goals, objectives, and strategic initiatives. The mission of the ACS as approved by the Board states that "the American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment." The approved vision states in part that "as an association of surgeons, the American College of Surgeons is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients. The College provides a cohesive voice addressing societal issues relating to surgery." The primary focus of the College, as approved by the Regents, includes the areas of education, research and optimal patient care, advocacy and health policy, and member services. To provide assurance to its Fellows and their patients that the College will fulfill

its mission and implement its vision, the Board reviewed a series of goals and objectives for inclusion in the final version of the strategic plan.

To meet its goals and objectives, the Regents approved a reorganization of the College staff into four major divisions:

1. The Division of Education will coordinate all College activities in continuing surgical education, including increased ACS presence in Web-based learning, interactive education, and self-directed learning to assure life-long learning and competency.

2. The Division of Research and Optimal Patient Care will coordinate all College activities in this area to improve the delivery of care including coordinating ACS data banks and expanding the use of this critical information, especially in the areas of cancer, trauma, and outcomes.

3. The Division of Advocacy and Health Policy will coordinate all College activities in this area including developing a proactive, prioritized surgical agenda for public policy debate, and an agenda to further the quality care of the surgical patient.

4. The Division of Member Services will coordinate all programs and services developed for College members, chapters, advisory councils, and international activities. This will include creating a customer service center to support all ACS programs for members and developing enhanced programs for ACS chapters in education, planning, and support.

Study of Fellows

As part of the strategic planning process, the Regents reviewed the results of a survey of Fellows to obtain their responses for consideration in formulating the College's strategic plan. The survey, "Needs, Participation, Attitudes, and Assessment: The 2001 Study of Fellows," was conducted through a combination of mailed questionnaires, online questionnaires, and follow-up telephone interviews. The report is based on the responses of 1,217 Fellows from a probability sample of 2,399 Fellows, making a participation rate of 51 percent.

The results describe a population of Fellows who are actively engaged in their professional practices, substantially involved in continuing education, often involved in research, and concerned about the future of their profession. There is broad support for the quality of current College programs, but numerous Fellows want the College to become more actively involved in managed care issues, both in terms of contract negotiation and the development of standards, and in legislative and policy issues.

The Fellows indicated a clear preference for a stronger College role in advocating public policies to enhance the profession and the provision of high-quality medical services. A substantial proportion of Fellows is already active in the public policy arena, and Fellows strongly agree on the policy agenda that they want to advance.

Work groups' reports

As part of the strategic planning process, four work groups had previously been appointed to study various aspects of College program activity. Their reports were presented at the strategic planning meeting with recommendations as summarized below.

Work Group on Education

This work group suggested that the College: (1) create a Division of Education with global concepts; (2) appoint an advisory group to assist with the development of a comprehensive plan for education; (3) develop a continuing professional development curriculum based on the competencies of the American Board of Medical Specialties; (4) examine and revise the College's education mission statement to reflect the range and scope of its educational activities; (5) conduct a comprehensive needs assessment focusing on the educational needs of residents, young surgeons, and surgeons in long-term practice; (6) develop courses centered on customization and the individual needs of the membership; and (7) conduct a comprehensive assessment of new technology and techniques.

Work Group on Research and Optimal Patient Care

An internal work group of ACS executive staff met during the year to discuss the establishment of an ACS Office of Evidence-Based Surgery within the administrative structure of a Division of Research and Optimal Patient Care. The primary focus of the office would be outcomes measurement. The work group developed a business plan that was presented later in the strategic planning session. The areas discussed in the business plan included the relationship of the office to other ACS departments, goals and functions of the office, organizational structure, and initial staffing requirements.

Work Group on Advocacy and Health Policy

Among its major recommendations, this work group emphasized that the Regents should establish a permanent Regental Health Policy Steering Committee and that the College should create a mechanism whereby legislative and regulatory issues can be addressed in a timely manner and issues of public policy can be prioritized. A multispeciality Health Policy Steering Committee was created in December and met in February and May to address the College's advocacy and health policy agenda and to prioritize regulatory and legislative issues relating to the College and its Fellowship. This committee will work closely with the College's Health Policy and Advocacy Department to develop action plans for addressing these issues.

Work Group on Membership and Member Benefits

Among the recommendations of this work group were that the College should establish a routine program/benefit/service review process. The review should be conducted at least every three years, and should take into consideration program activities, program performance, program outcomes, and resource utilization. The work group also suggested that: (1) the College establish a routine review and approvals process for consideration of new

benefits, which would include a needs assessment, a review of member demographics, and creation of a strategy to reach the intended target audience; and (2) the College conduct a survey of qualified nonmembers to assess their needs and interests.

Break-out sessions

The four work groups, the Regents, and the ACS staff then met in break-out sessions. In general, the work groups reaffirmed the recommendations and concepts outlined in the reports described previously. Specifically, the following additional recommendations were made during the break-out sessions.

- In education, the break-out panel determined that the College's major goal in this area should be promoting continued professional development for surgeons, resident surgeons, and students in all surgical disciplines by providing educational interventions directed at the acquisition and maintenance of competence. Also, the College should incorporate all phases of the educational aspects of surgical research as a fundamental component of the educational process.
- In research and optimal patient care, the break-out group called upon the College to partner with both internal and external centers for evidence-based patient care to coordinate development, dissemination, and evaluation of data-driven standards to measure and improve quality of surgical care outcomes. The panel also said the ACS should collaborate with other organizations involved with surgical research and determine its impact on the quality of patient care.
- In advocacy and health policy, the break-out group emphasized the need for the College to develop a proactive, prioritized agenda for public policy debate and an agenda to further the quality care of the surgical patient. The panel also said the College should maintain an active presence in Washington and should enhance surgeons' understanding of issues in practice management, coding, collective bargaining, and political action.
- In membership and member benefits, the

break-out group called on the College to enhance its public relations activities to advocate effectively for patients and surgeons, improve communications between members and leaders of the ACS, establish a customer service approach to the provision of membership services, and explore opportunities to expand membership, both domestic and international.

Assessing the environment

The Regents heard a presentation by David Dranove, PhD, author of *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care*. Dr. Dranove provided a perspective on the health care environment to enhance the Regents' understanding of opportunities and threats that will affect organizational performance as it relates to health care.

Business plans

The Regents reviewed and took action on the following business plans:

National Trauma Data Bank™ (NTDB). The Regents approved the business plan supporting efforts to increase participation in the NTDB through additional resources that will permit additional trauma centers to contribute to the NTDB, and permit Web-based submission of data to the NTDB. This program enables individual trauma centers to improve their quality through local data collection and management, and by benchmarking their programs against national results to support quality improvement efforts.

Office of Evidence-Based Surgery. The first phase of the business plan to support current staffing for the administration of an ACS Office of Evidence-Based Surgery was approved by the Regents. The office will support the College's mission of promoting the highest standards of surgical care through evaluation of surgical outcomes in clinical practice. The office will also provide the best evidence on surgical practice through research that provides evidence-based information on health care quality and use, development of evidence-based practice guidelines, and development/

Highlights of the Board of Regents meeting

facilitation of clinical trials.

Branding/marketing program. The Regents deferred action on the business plan for a national branding/marketing program to strengthen brand identification for "FACS." The purposes of the program would be: (1) to promote Fellowship as a credential the public should look for when seeking surgical care; (2) to underscore the importance and value of membership in the College for Fellows and other members; (3) to attract surgeons who are not members of the

College and to encourage them to apply for Fellowship; and (4) to expand awareness of the College, its standards, principles, and expertise among legislators. The program would also communicate to the public the College's position that operations should only be performed by qualified surgical specialists. A detailed financial plan covering all aspects of this proposed national branding/marketing program will be presented to the Board of Regents at its October meeting.

American College of Surgeons

CAREER OPPORTUNITIES POSITION AND RESUME DATA BANK NOW ONLINE

A Career Opportunities Position and Resume Data Bank is now online on the American College of Surgeons' Web site at <http://web.facs.org/jobs/toc.htm>. The data bank is available to Fellows and resident and young surgeon members of the Candidate and Associate Society (CAS-ACS) and is being provided at no cost. It provides Fellows with a location for listing employment and fellowship openings, and with the ability to search a list of surgeons seeking employment or practice opportunities. CAS-ACS members seeking employment or fellowships can post their resumes and interests at no cost and can access the employment opportunity listings. All that is needed to use the data bank is an ACS membership identification number. For more information about this service or the CAS-ACS, contact Susan Grunwald at the ACS via e-mail at sgrunwald@facs.org or tel. 312/202-5231.

The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

John Howard Means, distinguished professor of medicine, wrote, “The most conspicuous change in the behavior of the doctor is that nowadays he is usually in such a hurry that he is less accessible and less communicative.” That statement appeared in *Daedalus* 92, 1963. During the ensuing four decades, that statement would be amplified by geometric proportions.

In the October issue of the *Journal of the American College of Surgeons* we continue the section focusing on palliation and end-of-life considerations (“Communication: Part of the surgical armamentarium,” p. 450-453). As emphasized in the article itself, communication between the physician/surgeon and the patient is the vital element in palliative care and end-of-life issues; defined processes exist for improvement in these communication skills.

According to the *Oxford English Dictionary* (*OED*), communication is “to make common, to share, and to impart.” This necessitates an appreciation of the patient’s condition on the part of the physician/surgeon. It is somewhat ironic that the issue of communication is highlighted in a section concerned with palliation. Palliation, according to the *OED*, originally meant “to cover with a cloak, to hide, or conceal.” Palliation in its *current* context should apply the cloak to provide warmth and to assuage discomfort.

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the *Journal of the American College of Surgeons* and a Past-President of the College.

INTRODUCTORY ABSTRACT from the October lead article

Prospective Results of a Standardized Algorithm Based on Hemodynamic Status for Managing Pediatric Solid Organ Injury. John R Mehall, MD, Jared S Ennis, BS, Daniel A Saltzman, MD, PhD, John C Chandler, MD, Harsh Grewal, MD, Charles W Wagner, MD, Richard J Jackson, MD, Samuel D Smith, MD, FACS. From the Department of Pediatric Surgery, Arkansas Children’s Hospital, Little Rock, AR.

Background: Controversy surrounds the need for ICU admission, prolonged bed rest, and the duration of activity restrictions for children sustaining blunt trauma. Adult literature supports management based on hemodynamic status, not CT grade.

Study design: A 3-year prospective study of a standardized management algorithm for hemodynamically normal pediatric patients with blunt liver or spleen injury was performed. Patient selection was based on vital signs, irrespective of injury grade on CT. Patients requiring ICU admission for nonliver or nonspleen injury were excluded. Patients were admitted to a surgical ward with records of serial hematocrit levels. Discharge occurred 48 hours postinjury if patients had no abdominal tenderness,

tolerated a regular diet, and had a stable hematocrit. Patients were allowed noncontact activity, including school, after discharge. Patients were followed at 1 month with ultrasonographic imaging.

Results: Eighty-nine patients sustained blunt liver or spleen injury or both. Forty-five patients were excluded for other injuries (Glasgow Coma Score <13, 32 of 45); the remaining 44 patients had a mean age 8.9 years (range 2 to 17 years), Injury Severity Score 10.6 (range 4 to 33), liver grade 2.1, and splenic injury grade 2.3. Mechanisms of injury were predominately motor vehicle collisions (59%). All patients were managed nonoperatively without transfusion; 43 of 44 patients completed the algorithm. Mean observation was 55.2 ± 12.3 hours. One-month followup occurred in 33 of 44 patients, with one complication detected and no delayed bleeding.

Conclusions: Management of pediatric solid organ injury should be guided by hemodynamic status and not injury grade on CT. Hemodynamically normal children can be safely managed without intensive care monitoring, do not need prolonged hospitalization, and can resume school on discharge.